Health Care Financing

Research & Demonstration Series

REPORTS
RD
27
.43
M5
C37
1978

Report No. 5

Second Surgical Opinion Medicare Demonstration: Metropolitan Detroit

Department of Health, Education & Welfare • Health Care Financing Administration

RD
27.43
.M5
C37
1978

MEDICARE SURGICAL SECOND OPINION PROGRAM

Final Protocol

Blue Cross and Blue Shield of Michigan

by

Alejandro P. Caragay, M.P.H.

and

Ann Simpson, B.A.

This report is made pursuant to contract #600-77-0123 between the Health Care Financing Administration, Department of Health Education and Welfare and Blue Cross and Blue Shield of Michigan. The amount charged to the Department of Health, Education and Welfare for the work resulting in this report (inclusive of the amounts so charged for any prior reports submitted under this contract) is
The names of the persons, employed or retained by the contractor, with managerial or professional responsibility for such work, or for the content of the report, are as follows: Louis F. Hayes, M.D., Ann Simpson and Alejandro P. Caragay.

The Project Officer for this contract is Trudi W. Galblum, a staff member within the Office of Demonstrations and Evaluation, Office of Policy, Planning and Research. The views and opinions expressed in the report are the contractor's and no endorsement by the Health Care Financing Administration or Department of Health, Education and Welfare is intended or should be inferred.

ACKNOWLEDGEMENT

I wish to express my appreciation to those staff members from various areas of Blue Cross and Blue Shield of Michigan whose extensive involvement and assistance made possible this Final Protocol of the Medicare Surgical Second Opinion Program.

In particular, I wish to express my appreciation to Louis F. Hayes, M.D., Project Director for the MSSOP and Group Vice President, Professional Affairs, BCBSM for his solid support since the inception of this program. In addition, my appreciation is also extended to Mr. David B. Siegel, Director, BCBSM Health Services Planning and Development.

I am especially indebted to Mrs. Ann Simpson, Manager, Medical Planning and Development, who made significant contributions to the overall development of this protocol. Mrs. Simpson worked closely with me in this effort and provided her valuable contributions, constructive comments and encouragement.

I wish to thank also Ms. Mary Ann Olejniczak who worked on the typing of this document in an admirable fashion, and completed it within the limited time constraints imposed on her.

Alejandro P. Caragay, M.P.H.
Administrator
Second Opinion Referral Center
August 31, 1978

ABSTRACT

The Medicare Surgical Second Opinion Program is a three year demonstration program, beginning August 1, 1978, conducted by Blue Cross and Blue Shield of Michigan (BCBSM) for the Health Care Financing Administration.

During this period, Medicare beneficiaries residing in Wayne, Oakland and Macomb counties of Michigan can obtain a second opinion on elective surgeries they have discussed with their physicians. It is not essential that surgery be recommended as the next therapeutic step. However, if surgery is recommended, the surgery must be performed in the hospital (on an inpatient or outpatient basis) or at a free standing ambulatory surgi-center. A third opinion will also be available whether the consultant agrees or disagrees with the recommendation of the beneficiary's physician.

Participation in this program is entirely voluntary and the decision to undergo surgery remains with the beneficiary without loss of Medicare benefits.

Consultations will be arranged for the beneficiary by Registered Nurses from the BCBSM Referral Center. The consultants are board certified surgeons (M.D., D.O., D.D.S., or D.P.M.) who have voluntarily agreed to participate in this program by signing a Participating Agreement. In some cases, consultations arranged by the beneficiary, by-passing the Referral Center, will be paid provided certain program criteria are met.

Costs of the second/third opinion consultation will be paid in full, including copayments and deductibles, provided the consultation is approved by the Referral Center. Ancillary services ordered by the consultant, except when performed on a hospital inpatient basis, will also be paid in full. The claims for the consultation and related ancillary services will be mailed directly to the Referral Center for approval and pricing, and will then be sent to the appropriate claims processing area. If the beneficiary had out-of-pocket expense related to the second/third opinion, such expense will be reimbursed by the program.

With assistance from the numerous organizations, agencies and groups which service senior adults in the community and also from the local media, BCBSM will launch a vigorous publicity campaign to promote this program prior to its implementation and also throughout the program's duration. Various publicity materials, such as brochures, posters and slide presentations will be used to reach the Medicare population in the community.

Data needed for the program's evaluation will be collected by BCBSM on various operational forms and from the BCBSM Medicare Part A and Part B History file. The data will be provided to HCFA or its designated evaluator.

TABLE OF CONTENTS

Section I -- Introduction	Page
A. Background	1
B. Current Medicare Coverage for Second Opinions	4
C. Purpose of the Second Opinion Program	5
Section II -- Design	
A. Program	6
B. Research	10
Section III -- Consultants	
A. Qualifications	25
B. Recruitment	25
C. Responsibilities	26
Section IV -- Consumer/Provider Education and Marketing	
A. Public Relations Objectives	30
B. Audience	30
C. Reaching the Audience	32
D. Establishing a Link of Participation	32
E. Using Organization Support and Other Resources	37
F. Coordination of Organization Support	38
G. Public Relations Materials Needed by Supporting Organizations	38
H. Distribution of Materials	42
I. Provider and Professional Relations Support Activities	44

TABLE OF CONTENTS - (Continued)

	Page
J. Start-Up Activities/Formal Introduction of the MSSOP	45
K. Area Outreach Meetings	46
L. Leadership Training Program	47
M. Principal Media-Related Activities	47
N. Forward Planning and Ongoing Education	48
Section V -- Referral Center	
A. Location and Administration	54
B. Functions	54
C. Operational Staff	54
D. MSSOP Project Management	55
E. Special Additional Support Personnel	56
Section VI -- Administrative Procedures	
A. Scheduling a Second/Third Consultation Through The Referral Center	58
B. Eligibility Determination Procedures for Beneficiaries Seeking Second Opinions	60
C. Eligibility Determination for a Beneficiary Who Had a Patient or Doctor-Arranged Second Consultation Appointment with a Program Consultant	63
D. Obtaining a Third Opinion Through the Referral Center	64
E. Data Collection for the MSSOP	65
F. Follow-up on Consultant's Report and Claim Form Not Received	77
G. Logging Procedures	78

TABLE OF CONTENTS - (Continued)

	Page
H. Filing of Second/Third Consultation Cases (Beneficiary's File)	79
I. Filing of Consultants' Records, Except Consultants' Reports	82
J. Filing of Miscellaneous MSSOP Communications	83
K. Index Card File of Consultants	83
L. Data Conversion/Reporting	84
M. Privacy of MSSOP Records	85
Section VII -- Claims Processing	
A. Referral Center Claims Review	86
B. Manual Operations Area -- Claims Processing	93
C. Computer Claims Processing	94
D. Computer Edit Error Write-Offs	95
E. Provider Checks	95
F. Beneficiary Checks and Explanation of Medicare Benefit Forms	95
G. Maintaining Second Opinion Demonstration Claims History	95
H. Corrective Actions Taken for Payment Records Rejected Under the Experiment	96
I. Flow Chart	97
Section VIII -- Processing of SSA-1483 Part B Claims by Part A Intermediary	
A. Problem	101
B. Submission of SSA-1483	101

TABLE OF CONTENTS - (Continued)

	Page
C. Referral Center Claims Review	101
D. Reimbursement	102
E. Auditing	102
F. Adjustment	102
G. Alternatives Considered for Processing SSA-1483 Part B Claims by Part A Intermediary	103
Section IX -- Policy Decisions on Coverage and Operation of the Program	106
Section X -- Importance of MSSOP in View of National Second Opinion Initiative of DHEW	108

TABLE OF APPENDICES

		Page
APPENDIX 1:	Grand Rapids PSRO Tentative Phase-In Schedule - Binding Review	A-1
APPENDIX 2:	Wayne County PSRO Public Notice - Binding Review	A-2
APPENDIX 3:	Participating Agreement	A-5
APPENDIX 4:	Addendum Agreement	A-6
APPENDIX 5:	BCBSM Position on Professional Liability Coverage	A-7
APPENDIX 6:	Letter of Invitation to Eligible Surgeons	A-8
APPENDIX 7:	Letter of Invitation to Current Consultants	A-10
APPENDIX 8:	Follow-up to Letter of Invitation to Eligible Surgeons	A-12
APPENDIX 9:	Physician's Reply Card	A-14
APPENDIX 10:	Suggested Article for Newsletter	A-15
APPENDIX 11:	Letterhead with Program Identity Symbol	A-17
APPENDIX 12:	MSSOP Brochure	A-18
APPENDIX 13:	MSSOP Poster	A-23
APPENDIX 14:	MSSOP Envelope Stuffer	A-24
APPENDIX 15:	MSSOP Wallet Card	A-25
APPENDIX 16:	Announcement Letter to Area Physicians	A-26
APPENDIX 17:	Announcement Letter to Area Hospitals, Nursing Homes	A-28
APPENDIX 18:	Announcement Letter to Organizations, Groups and Agencies Related to Senior Adults	A-30
APPENDIX 19:	MSSOP "Needs" Survey	A-32
APPENDIX 20:	MSSOP Description Booklet	A-34

TABLE OF APPENDICES (Continued)

		Page
APPENDIX 21:	MSSOP Consultant's Manual	A-43
APPENDIX 22:	MSSOP Referral Center Intake Form, HCFA-36T	A-51
APPENDIX 23:	Cover Letter for Consultant's Package	A-52
APPENDIX 24:	MSSOP Consultant's Report, HCFA-38T	A-54
APPENDIX 25:	Request for Medicare Payment, HCFA-1490(2)	A-55
APPENDIX 26:	Instructions for Submitting Ancillary Services Claims, Excluding Those Performed at the Consultant's Office	A-57
APPENDIX 27:	First Opinion Physician's Report, HCFA-37T	A-58
APPENDIX 28:	MSSOP Confirmation of Appointment Card	A-59
APPENDIX 29:	List of Railroad Retiree HIC Numbers	A-60
APPENDIX 30:	List of Valid Medicare HIC Numbers	A-61
APPENDIX 31:	Request for Medicare Payment, SSA-1483	A-62
APPENDIX 32:	Medicare Development Checklist	A-63
APPENDIX 33:	Medicare Part B Pricing Attachment	A-65
APPENDIX 34:	Monthly Intermediary Financial Report	A-66
APPENDIX 35:	Payment Voucher on Letter of Credit Transmittal	A-70

I. INTRODUCTION

A. Background

The rate of surgery performed in the United States has increased dramatically since 1971. According to the Hospital Discharge Survey[1] available from the National Center for Health Statistics, 1971 showed an annual rate of surgery of 7,805 per 100,000 population and this rate has been increasing annually. In 1975, the rate had escalated to 9,585 per 100,000 population. Compared to the rate of population increase between 1971 to 1975, the annual rate of surgery increased at a rate $3\frac{1}{2}$ to 4 times greater than the population increase.[2]

A significant portion of the rising health care costs in the United States can be attributed to the fact that a high percentage of all patients discharged from short-stay hospitals have undergone surgery. In 1975, there were 14.2 million or 41.7 percent of all patients discharged from short-stay hospitals who had surgery.[3]

Approximately $47 billion was spent for costs of hospital care in 1975. The National Center for Health Statistics[4] has reported that during 1976 the costs of hospital care increased almost 20 percent over the previous year and costs, based on projections, will continue to increase. As stated, approximately 41.7 percent of all patients discharged from short-term hospitals underwent surgery. The necessity for some of this surgery has been questioned. If in fact some degree of unnecessary surgery is being performed, this would effect the total cost of hospital care.

Through the years, many investigators have studied surgical utilization. Since 1970, an increasingly growing body of research has indicated the existence of wide variations in surgical rates between hospital/regional

---

[1] National Center for Health Statistics. Hospital Discharge Survey Data, May 1975.

[2] McCarthy, E., M.D., "Second Opinion Elective Surgery Consultation Program: Prepared Testimony". Hearings before the Subcommittee on Oversight and Investigations of the Committee on Interstate and Foreign Commerce, House of Representatives, May 2, 1977, p. 3.

[3] National Center for Health Statistics, "Utilization of Short-Stay Hospitals: Annual Summary for the United States, 1975," Vital and Health Statistics, Series 13 - Number 31.

[4] National Center for Health Statistics, Hospital Discharge Survey Data, May 1976.

areas,[5,6] socioeconomic groups[7,8] and financing arrangements[9]. In a landmark study presented by John P. Bunker, M.D.[10] in 1970, it was revealed that, in relation to its population, the U.S. has twice the number of surgeons and twice the surgical rate of England and Wales. Bunker hypothesized that the U.S. may have too many surgeons for its population, and this situation may result in surplus surgery. Lewis[11] in his study has suggested that patient admissions for surgery expand to fill beds, operating suites and surgeon's time.

Rates of surgery performed on Medicaid beneficiaries in some states are characterized by large variances relative to the national average for identical procedures[12]. As an example, in 1973 Medicaid beneficiaries

---

5 Bunker, J.P., M.D., Barnes, B., M.D., and Mosteller, Frederick, Ph.D., editors. "Costs, Risks and Benefits of Surgery" Oxford University Press, New York, 1977.

6 Wennberg, J., and Gittleson, A., "Small Area Variations in Health Care Delivery." Science 182: 1102-1108, 1973.

7 Bunker, J.P., M.D., and Brown, B.W., M.D. "The Physician Patient as Informed Consumer of Surgical Services." New England Journal of Medicine, 290: 1051-1055, 1974.

8 Vayda, E., M.D., "A Comparison of Surgical Rates in Canada and in England and Wales." New England Journal of Medicine, 289: 1224-1229, 1973.

9 Gaus, C.R., Sc.D., Cooper, B.S. and Hirschman, C.G., "Contrasts in HMO's and Fee-for-Service Performance." Social Security Bulletin, Vol. 39, No. 5, p. 3-14, May 1976.

10 Bunker, J.P., "Surgical Manpower: A Comparison of Operations and Surgeons in the United States and in England and Wales". New England Journal of Medicine, 282: 135-144, 1970.

11 Lewis, C.E., M.D., "Variations in the Incidence of Surgery." New England Journal of Medicine, 281: 880-884, 1969.

12 Hearings before the Subcommittee on Oversight and Investigations of the Committee on Interstate and Foreign Commerce, House of Representatives, 94th Congress, First Session. "Getting Ready for National Health Insurance: Unnecessary Surgery," July 15, 17 and 18 and September 3, 1975, serial No. 94-37. (Preliminary Report of the Results of a Questionnaire Sent to State Medicaid Agencies Concerning Costs and Fees," p. 263-266.

in the District of Columbia and North Dakota experienced rates of 1.9 and 1.5 times the national average for hemorrhoidectomies and prostatectomies, respectively. Significant variations were also found to exist in surgery rates per 100,000 for 1974 within the same regions, as reported by the Subcommittee on Oversight and Investigations of the Committee on Interstate and Foreign Commerce.[13]

Although many studies have been done on the quantity and quality of surgery performed in this country, they are traditionally retrospective in nature, i.e. review of medical records by a panel of specialists after the service has been performed. Emerson illustrated a retrospective review technique to assess medical care and surgical utilization, using preset criteria predictors for the review of medical records.[14] Two other studies using medical records in a retrospective review of cholecystectomies and hysterectomies were reported by the Quality of Care Committee of the New York Medical Society in 1970[15] and in 1972.[16]

Recently, second opinions have been promoted as a method of prospective review prior to recommended elective surgeries. In 1974, Eugene McCarthy and Geraldine Widmer[17] of Cornell University Medical College published the preliminary results of a study of the utilization of second opinions by union members in New York. For this study, they used a "before-the-surgery" approach in assessing the need for elective surgery, rather than the usual "after-the-surgery" approach. Both mandatory and voluntary programs were studied in which patients for whom elective surgery was recommended secured a second opinion from a board certified specialist prior to their surgeries. The results showed that 30 percent of the second opinions given under the voluntary program and 18 percent given under the mandatory program did not confirm the opinion of the patients' physicians. This study clearly identified that there is a significant divergence of opinion between patients' physicians and the second opinion surgical consultants on the need for surgery.

---

[13] Ibid.

[14] Emerson, Ralph, "Unjustified Surgery, Fact or Myth?", New York State Journal of Medicine, October, 1970, pp. 412-425.

[15] Report of the Cholecystectomy Subcommittee of the Quality Care Committee, New York Medicine, October, 1970, pp. 412-425.

[16] Report of the Hysterectomy Subcommittee of the Quality Care Committee, New York Medicine, January, 1972, pp. 17-23.

[17] McCarthy, E.G., and Widmer, G.W., "Effects of Screening by Consultants on Recommended Elective Surgical Procedures", New England Journal of Medicine, December 19, 1974, Volume 291, pp. 1331-1335.

In the summer of 1975, the Congressional Oversight and Investigations Subcommittee of the Committee on Interstate and Foreign Commerce held hearings on unnecessary surgery. Using the results of the McCarthy study, the Subcommittee concluded that "there were approximately 2.4 million unnecessary surgeries performed in 1974 at a cost to the American Public of almost $4 billion (and leading to) 11,900 deaths."[18]

Though the implications of the various studies on surgical utilization can be debated, it is generally agreed that some amount of unnecessary surgery is occurring, but the extent of this surplus surgery is still unclear. Estimates range from the Moss Committee's figure that 2.38 million unnecessary surgical procedures were performed in 1974, to Emerson's estimate that less than 1 percent of all surgeries are unjustified.[19]

The Subcommittee recommended that DHEW mandate second opinions under Medicare and Medicaid and closely evaluate the results of such a program in terms of the impact on the percentage of surgeries considered unnecessary, on quality of care, and costs.[20] In May, 1977, DHEW requested the submission of bids on a surgical second/third opinion pilot program.[21] Contracts were awarded in September, 1977 to Blue Cross and Blue Shield of Michigan and Blue Cross and Blue Shield of Greater New York to conduct these pilot/demonstration programs. Further, in November, 1977, Hale Champion, Under Secretary of DHEW, told the subcommittee that DHEW would promptly encourage all Medicare beneficiaries to obtain a second/third opinion prior to elective surgery.[22]

B. Current Medicare Coverage for Second Opinions

As a result of Hale Champion's directive, the Health Care Financing Administration (HCFA) began to encourage Medicare beneficiaries to seek a second/third opinion consultation prior to a recommended elective

---

18 Subcommittee on Oversight and Investigations, op. cit.

19 Emerson, Ralph, op. cit.

20 Subcommittee on Oversight and Investigations, op. cit.

21 RFP IAD-59, SSA-RFP 77-0282, Department of Health, Education and Welfare, May, 1977.

22 Statement by Hale Champion, Under Secretary of Health, Education and Welfare before the Subcommittee on Oversight and Investigations, Committee on Interstate and Foreign Commerce, House of Representatives. Continuation of Unnecessary Surgery Hearings, November 1, 1977.

surgical procedure. The Medicare program will pay for the costs of such a consultation and for any ancillary services related to the consultation. Applicable deductibles and copay provisions still apply.[23] The primary difference between the second opinion demonstration programs and the national effort to encourage second opinions, from a standpoint of reimbursement, is that beneficiaries covered under the demonstration programs have no coinsurance or deductible liability for the consultant's fee or any of the ancillary services ordered by the consultant, if their second opinion consultation appointment is arranged through the BCBSM Referral Center. The establishment of structured Referral Centers also distinguishes the demonstrations from the national effort.

C. Purpose of the Second Opinion Program

The contract awarded by HCFA to Blue Cross and Blue Shield of Michigan (BCBSM) will provide second/third surgical opinions so that an evaluation can be conducted by HCFA. This evaluation will help to determine the effect of optional second/third opinions on the quality of surgical care, on surgical rates, and on associated costs.

To achieve the objectives of the HCFA, the BCBSM design will focus on providing the HCFA with data from which to evaluate the impact of a pre-surgical consultation in order to determine such outcomes as:

- The effect on surgical utilization, i.e. changes in the frequency and prevalence of elective surgical procedures in the control group and in the treatment group.
- The estimated cost effectiveness and cost containment potential.
- Whether there are differences in surgical utilization between a PSRO area with a second opinion demonstration program and a PSRO area without a second opinion program.
- The deterrent (sentinel) effect on decision making by physicians.

---

[23] Part B Intermediary Letter No. 77-40, Subject: Second Opinions on Surgery. November, 1977.

II. DESIGN

A. Program

The second opinion program being administered by Blue Cross and Blue Shield of Michigan is known as the Medicare Surgical Second Opinion Program or the MSSOP. From August 1, 1978 until July 31, 1981, second/third opinions relating to elective (non-emergency) surgeries can be obtained, on an ambulatory basis, by Medicare beneficiaries who reside within the designated experimental area.

Second/third opinion consultations can be obtained only in the experimental area and must be arranged through the Referral Center established for this program.

1. Experimental Area

The Michigan counties of Wayne, Oakland and Macomb (the Detroit Tri-County area) comprise the experimental area in which Medicare beneficiaries will be able to obtain consultations through the BCBSM Medicare Surgical Second Opinion Program, without liability for copayments and deductibles. The experimental area is discussed more fully in Item B.1, page 11.

2. Eligibility

For a beneficiary to request a second opinion through the MSSOP, he/she must:

- Reside in the designated experimental area, i.e. Wayne, Oakland or Macomb counties in Michigan.
- Have current Medicare Part B Medical Insurance serviced by BCBSM.
- Have discussed surgery with his/her physician within 120 days[24] prior to the date of seeking consultation. The discussion of surgery must be related to the condition for which the beneficiary seeks consultation. If surgery is to be performed, it must be in a setting other than at the doctor's office.
- Arrange the second/third opinion consultation through the Referral Center established for this program.

---

[24] When deemed medically appropriate, exceptions to this limitation may be made at the discretion of the Referral Center supervisor in consultation with the Referral Center Administration.

3. Coverage

Under this program, second surgical opinions provided by participating surgical consultants on surgery as the next treatment step, and including any radiology or laboratory tests needed by the consultant to make an assessment are available to eligible beneficiaries.

A beneficiary can request a second opinion consultation whether his/her physician, hereafter referred to as the First Opinion Physician or FOP, recommends or does not recommend surgery.

A third opinion can also be obtained through this program by any eligible beneficiary who requests it, regardless of the outcome of the second opinion consultation.

Whatever the recommendation of the second/third opinion consultant, the beneficiary is not compelled to accept the recommendation of the consultant. The beneficiary, if he/she decides to do so, may proceed to have the surgery without loss of Medicare benefits, even if the consultant recommends against surgery. Diagram 1 displays the possible decisions a beneficiary might make within the program.

4. Surgical Procedures Eligible for Second or Third Opinions

Second/third opinion consultations can be obtained for any elective (non-emergency) surgical procedure which could possibly be performed on a hospital inpatient basis, a hospital outpatient basis, or in a free standing ambulatory surgical center.

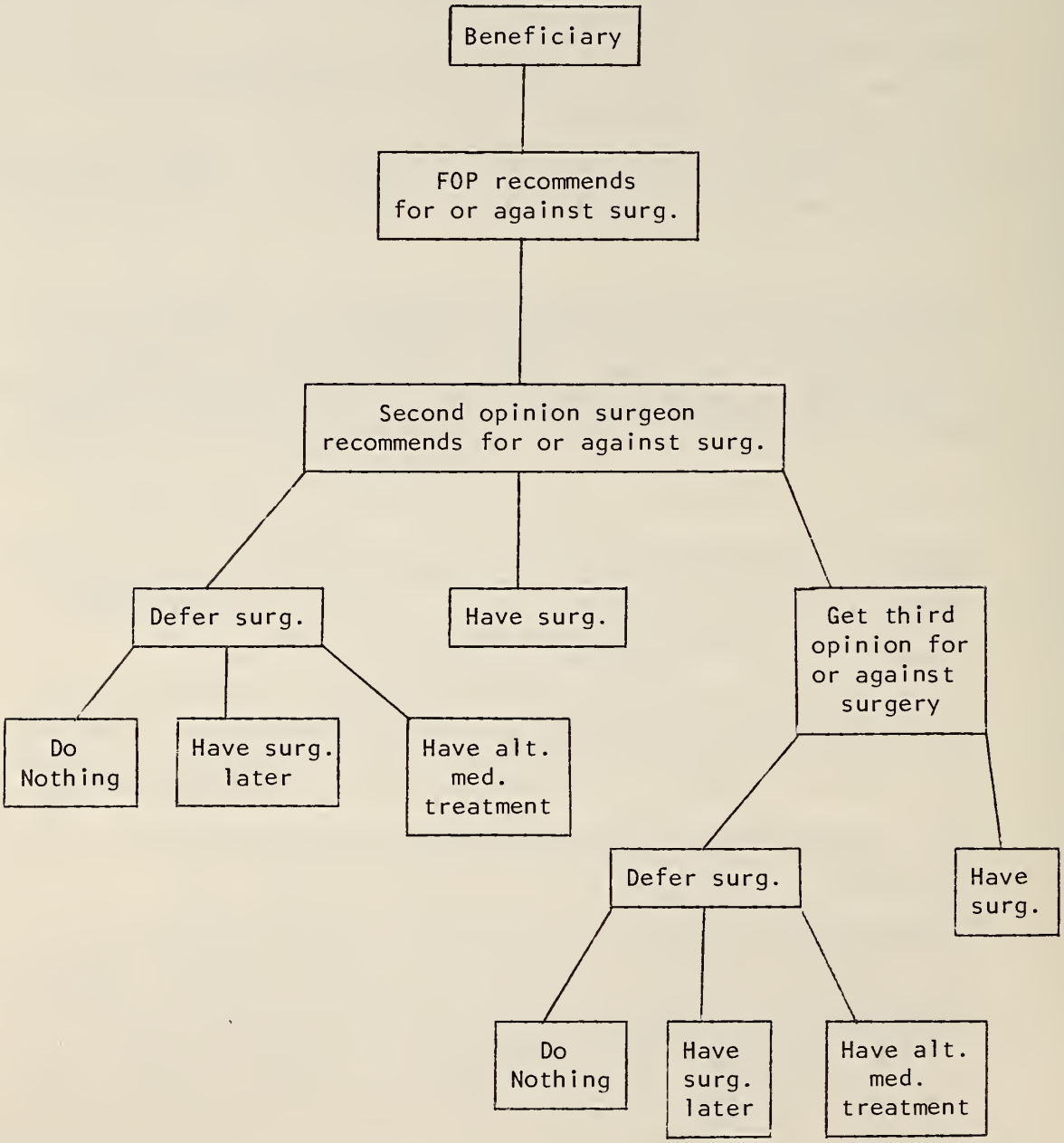
Under the MSSOP, elective surgery is defined as surgery which is not considered an emergency or life threatening but is subject to the choice or decision of the beneficiary or physician. It does not imply any judgement as to medical necessity or deferrability.

5. Surgical Procedures/Situations Not Eligible for Second or Third Opinions

Some services are specifically excluded from Medicare payment by section 1862 of the Social Security Act, such as cosmetic surgery, the removal of teeth in the absence of underlying medical problems which would require hospitalization for these extractions, and routine foot care including the cutting or removal of corns, warts or calluses. Second opinions requested for these procedures will have to be denied on the basis that the service itself is specifically excluded from coverage under the Medicare statutes.

DIAGRAM 1:

Possible Decisions a Beneficiary May Make Within the MSSOP



FOP - First Opinion Physician

Surg. - Surgery

Alt. med. treatment - Alternative medical treatment

Also, the following procedures/situations exclude a beneficiary from receiving a second/third opinion consultation under the MSSOP:

- o Surgeries performed in the doctor's office
- o Surgeries performed as a result of trauma
- o All normal vaginal deliveries
- o Abortions
- o Surgical procedures which are Medicare contract exclusions
- o Second opinion consultations arranged other than by the Referral Center, except as described in Item 9, page 10.
- o Hospital inpatient consultations -- unless an MSSOP participating consultant, with privileges at the hospital in which the patient is hospitalized, can see the patient during the hospitalization.

6. Participation

Participation in this program is entirely voluntary for both Medicare beneficiaries and for those surgeons who serve as program consultants. For the purpose of this program, voluntary means:

- o The beneficary has the free choice to request a surgical second/third opinion.
- o The beneficiary is not compelled to accept the advice of the second/third surgical consultant.
- o The beneficiary is free to either undergo surgery or refuse it, without loss of Medicare benefits.
- o The individual board certified surgeons in the experimental area may choose freely whether or not to serve as program consultants.

7. Consultant's Fee

Payment will be made to consultants for services rendered to beneficiaries based on their charges, but not to exceed $50 per consultation. The amount paid to the consultant by the program will represent payment in full, and the consultant will not bill an additional amount to the beneficiary. If the consultant charges more than the $50 ceiling, the charge will be reduced to $50.

The professional charges for the second or third opinion consultation will not be subject to either deductibles or copayments. Claims for professional services rendered will be paid through experimental waiver of copay and deductible.

8. Coverage for Diagnostic Tests

The consultant may order any diagnostic tests needed to assist in the evaluation of the beneficiary's condition, provided such tests are covered benefits under Medicare Part B. The charges for diagnostic tests performed will not be subject to either deductibles or copayments. Claims for diagnostic services rendered will be paid through experimental waiver of copay and deductible, if such services were performed on an ambulatory basis.

If the beneficiary is hospitalized for testing, costs of the hospitalization and diagnostic services will be covered under Medicare Part A and will be subject to the usual deductible and copayments. However, the consultant's fee will be paid in full, as described in Item 7 preceding.

9. Self Arranged Second Opinion Consultations

Second/third opinion consultations are arranged for the beneficiary by the Referral Center. However, should a beneficiary arrange his/her own second opinion consultation with a participating program consultant, bypassing the Referral Center, such consultation can be covered by the program provided the claim has not been submitted to BCBSM. The beneficiary must inform the Referral Center of his/her self arranged second opinion consultation prior to the claim being submitted by the consultant.

An adjustment cannot be made once the claim is submitted to BCBSM. In order to retrieve a claim from the Part B carrier, major system changes would be required.

10. Special Reimbursement Provision

Section 1862 of the Social Security Act also prohibits payment for services which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member. Because the patient may not know in advance whether the surgery being considered is reasonable and necessary, reimbursement will be made for a second opinion, even if it is later determined that the surgery itself was not reasonable and necessary.

B. Research

The experimental area for the MSSOP is comprised of Wayne, Oakland and Macomb counties in Michigan. In addition to the experimental area, two

additional areas have been chosen and designated as the control areas. Tables 1 to 8 (pages 17 to 24) display the various characteristics of the experimental and control areas considered. All the areas are similar in character to each other, thus facilitating the evaluation of the program by an independent evaluator chosen by the HCFA.

1. Characteristics of the Experimental Area

Experimental counties are located within the Detroit Standard Metropolitan Statistical Area (SMSA). As of 1975, the Tri-County area had a provisional general population of 4,173,800, constituting nearly half of the population of Michigan. During the 1950s and early 1960s the area experienced rapid growth in population due to an influx of those attracted by employment prospects in automobile related industries. The trend has now reversed and net outmigration is increasing, particularly from Wayne County, the largest county in the state. Detroit, with approximately half of Wayne County's total population is currently experiencing an annual decrease in excess of 25,000 people.

It is projected that only a slight population increase (approx. 0.1% per year) will occur through 1990 in this area, however, a dramatic shift will be apparent in the age composition. In 1970, there were 1,668,000 people (39.7%) under 19 years of age in the area, 2,190,000 people (52.1%) ages 20-64 years, and 342,000 people (8.2%) ages 65 and over. By 1990, the projection is that the under 19 population will decrease by approximately 25% while the 65 and over population will increase approximately 43%.

Out of a total labor force in the Tri-County area of approximately 1.9 million, 142,200 (7.5%) are listed as unemployed. The working labor force is primarily employed in manufacturing (33.7%) and in the wholesale and retail trade (19.7%).

The median school years completed in the Tri-County area is 11.9 years, which is close to the State's median average of 12 years.

For the area as a whole, exclusive of Detroit, the rates for most health related indices are lower than comparable figures for the rest of Michigan. The city of Detroit, like most major U.S. cities, is largely and increasingly inhabited by the poor, the aged, and the community dependent, and this distorts the health indices for the area as a whole.

The Tri-County area has approximately 6,800 physicians or 153/100,000 population, largely due to the presence of Wayne State University School of Medicine, specialized hospital facilities, higher than average incomes, and high levels of demand for various services. There are 71 hospitals with 18,435 beds, or approximately 384 beds/100,000 population. Most facility and other health personnel rates are comparable to state rates.

Specifically, for the Medicare population in the Tri-County area, there are an estimated 364,699 beneficiaries as of 1976, and this represents over 1/3 of all beneficiaries in Michigan. There are 1,242 surgeons practicing in this area which gives a ratio of 3.4 surgeons per 1,000 beneficiaries. Further, the experimental area contains a broad range of certified and non-certified surgical specialties.

By choosing the Tri-County as the experimental area, comparative studies should be possible between the Medicare populations in the experimental area and in the control areas. Also, comparative and contrast studies may be made between the MSSOP and the results of the second opinion program for Auto members in the Tri-County area, provided the data from the Auto second opinion are available and can be released to the evaluator of the MSSOP.

2. Characteristics of the Control Group

In selecting the Control areas for this program, the following factors were taken into account:

- The control groups should be similar to the treatment group in terms of benefits, demographic characteristics, physician/population ratio, surgeon/beneficiary ratio, availability and accessibility of health care resources, level of education in the area, level of industrialization, etc.

- The control groups should not have access to the surgical second opinion programs, as defined herein.

- The control groups should be located in a Standard Metropolitan Statistical Area (SMSA).

Two areas outside the experimental area, namely the Flint area and the Grand Rapids area, were selected as controls for the MSSOP.

a. Control Group 1 - Flint Area

The Flint area is located proximal to the experimental area and consists of the Michigan counties of Genesee, Lapeer and Shiawassee. These counties are located in Standard Metropolitan Statistical Areas. As of 1975, the Flint area had a provisional general population of 582,100 with approximately one third of the population living in the City of Flint, a highly industrialized city which is the third largest city in Michigan.

For many years the high paying industries of Flint attracted younger residents from other areas of Michigan and from out-of-state. This has resulted in a relatively young population with 215,000 people (43.4%) under 19 years of age, and 247,000

people (50%) ages 20 to 64 years while only 32,000 people (6.6%) are 65 years or older, based on the 1970 census of population. Although the number of older residents is increasing 2.8% per year, this area is still expected to continue having a population younger than the state average. Due to the age distribution of the area population, the three counties have a higher than average birth rate and a lower than average death rate.

Employment in this area is primarily in automobile related industries. Of the total labor force of approximately 234,900, an estimated 43.4% are engaged in manufacturing, and 19.5% are engaged in the wholesale and retail trade. Based on 1977 data from the Bureau of Labor Statistics, 16,400 people (7%) are listed as unemployed.

The median school years completed in this area is 11.8 which is 0.2 years lower than the state average.

Although the number of physicians has increased 25% since 1970, there are only approximately 585 physicians or 113/100,000 population. Nine hospitals serve the Flint area and have a combined bed capacity of approximately 2,646 beds which is 447 beds/100,000 population.

This area has an estimated 38,596 Medicare beneficiaries as of 1976. One hundred thirty two surgeons practice in the Flint area, with the majority (116) located in Genesee county. The ratio of surgeons to beneficiaries for the entire area is 3.4/1,000 beneficiaries.

b. Control Group 2 - Grand Rapids Area

Two counties, Kent and Ottawa, comprise the Grand Rapids SMSA. This area is located approximately 150 miles from the experimental area. The Grand Rapids SMSA has a 1975 provisional population of 567,600 with 75% of the population located in Kent county, mainly in and around the City of Grand Rapids.

Based on the 1970 census, there were 226,000 people (41.9%) under 19 years of age, 265,000 people (49.2%) ages 20 to 64 years, and 48,000 persons (8.9%) were ages 65 years and older.

Given anticipated trends, the number of children and adolescents should decrease due to continuing low birth rates, the number in the working ages (18-64) will increase an average of 1.5% per year, and the 65 and older population will increase at an estimated annual rate of 0.07%.

Resources in the area having considerable economic influence include furniture, transportation equipment, machinery and special metal products insustries. Additional employment is provided in the area by the existence of three institutions of higher education.

Of the total labor force of 278,600 people, 80,900 (34.5%) are employed in manufacturing and 54,400 (23.2%) are employed in the wholesale and retail trade. Fifteen thousand people are classified as unemployed, that is approximately 5.4% of the labor force.

The median school years completed in the Grand Rapids SMSA is 12.0 years. This equals the state average.

Health resources are concentrated in Kent County which serves as a regional center in the provision of specialized hospital services for the west central portion of Michigan. There are an estimated 763 physicians (138/100,000 population) located in the Grand Rapids SMSA with the majority in Kent County. Eleven hospitals serve this area with a bed capacity of approximately 2,751 or 475 beds/100,000 population.

The Grand Rapids SMSA has an estimated 51,276 Medicare beneficiaries. One hundred and ninety six surgeons practice in this area with 175 (89%) located in Kent County. The surgeon to beneficiary ratio in the Grand Rapids SMSA is 3.8/1,000.

Compared with the other SMSAs (exclusive of the Flint SMSA), the Grand Rapids SMSA is the only other area in Michigan which meets the criteria set for choosing a control group.

3. Professional Standards Review Organizations

In Michigan, all ten designated PSRO areas are formally organized. Diagram 2 (page 15) shows the PSRO areas in Michigan. Since the MSSOP deals only with PSRO areas III, V, VIII and IX, this segment will discuss the level of activities for these particular PSRO areas. At present, surgical necessity review is not being conducted in any of these PSRO areas. However, it is known that a directive from the National Council of PSROs is being developed and will be sent soon to all PSROs instructing them to phase in surgical necessity review.

a. PSRO Area III (Grand Rapids)

Kent and Ottawa counties in this area comprise control group No. 2 in the MSSOP. The PSRO is known as Western Michigan PSRO and received conditional status in April, 1978. It is expected to assume responsibility for binding review beginning

DIAGRAM 2:

PSRO Areas in Michigan

* Reduction of original.

August, 1978. One hundred percent of T-18, T-19 and T-5 hospital admissions will be subject to review. PSRO activities will be delegated to most hospitals (Appendix 1).

b. PSRO Area V, PRO-GLSC (Flint Area)

PRO-GLSC (Flint Area) covers the counties of Genesee, Lapeer and Shiawassee. It received conditional status effective July 1, 1975. This area will be used as control group No. 1 in the Medicare Surgical Second Opinion Program and will be considered as the "well established PSRO" control. Presently this PSRO conducts concurrent admission and length of stay reviews for all T-18, T-19 and T-5 patients admitted to the nine area hospitals. It also conducts Medical Care Evaluation studies. For its review activities, PRO-GLSC used a Criteria Manual developed by its Criteria Committee. The review activities are considered as very good to excellent based on the BCBSM monitoring program and the Health Standard and Quality Bureau (HSQB) evaluation performed in 1977. The PSRO performs the review activities at seven hospitals, while two hospitals have been delegated to perform their own review.

c. PSRO Area VIII (Wayne County)

Wayne County has been designated as PSRO Area VIII and is known as the Federation of Physicians in Southeastern Michigan. This PSRO is located within the experimental area for the MSSOP. It received conditional status on July, 1977 and anticipates starting binding review by July, 1978. There are 52 short stay hospitals within the area and review activities will be delegated to the majority of these hospitals. At the onset, 12 hospitals will be selected to conduct binding review and the additional hospitals will be phased in (Appendix 2). It is anticipated that 100 percent of T-18, T-19 and T-5 hospital admissions will be reviewed.

d. PSRO Area IX (Oakland and Macomb Counties)

PSRO Area IX is in the planning stage at this writing. It is anticipated that this PSRO will receive conditional status in the late third quarter of 1978 and will conduct binding review by 1979.

There are 24 short stay hospitals within PSRO Area IX and the PSRO plans to delegate its activities to most of these hospitals. It is anticipated that 100 percent of T-18, T-19 and T-5 hospital admissions will be subjected to medical and length of stay review.

TABLE 1:

[1] Adapted Estimates of Population of Metropolitan Areas and Their Component Counties: Michigan, July, 1975 and April, 1970

Area	July 1, 1975 (Provisional)		April 1, 1970 (Census)	
	Number	Percent	Number	Percent
Detroit Area	4,173,800	100.0	4,204,443	100.0
Wayne	2,536,700	60.8	2,670,368	63.5
Oakland	967,500	23.2	907,871	21.6
Macomb	669,600	16.0	626,204	14.9
Flint Area	582,100	100.0	561,025	100.0
Genesee	450,400	77.4	445,589	79.5
Shiawassee	69,700	12.0	63,075	11.2
Lapeer	62,000	10.6	52,361	9.3
Grand Rapids Area	567,600	100.0	539,225	100.0
Kent	427,100	75.2	411,044	76.2
Ottawa	140,500	24.8	128,181	23.8

[1] Adapted from 1975 Vital Statistics extrapolations to to reflect only those counties listed above and located in Standard Metropolitan Statistical Areas.

Source: U.S. Bureau of Census, Current Population Reports: Population Estimates, Series P-26, No. 75-22; Issued May, 1976.

TABLE 2:

Years of School Completed for All Ages 14 Years and Over, for Both Sexes and All Races: 1970 Michigan Data

Area	Total	Elementary School Completed	High School Completed	College		Median School Years Completed
				4 Years	5 + Years	
State	6,359,588	830,442	2,010,343	278,582	209,902	12.0
PERCENT	100.0	13.1	31.6	4.4	3.3	
Detroit Area	3,019,569	356,284	946,189	134,155	101,325	11.9
PERCENT	100.0	11.8	31.3	4.4	3.4	
Flint Area	341,129	43,029	113,686	12,079	7,591	11.8
PERCENT	100.0	12.6	33.3	3.5	2.2	
Grand Rapids Area	381,370	55,429	116,925	18,442	11,220	12.0
PERCENT	100.0	14.5	30.7	4.8	2.9	

Source: U.S. Bureau of Census, Census of Population: 1970 Detailed Characteristics. Final Report PC (1) - D24 Michigan. Table 148.

TABLE 3:

Labor Force and Unemployment for State and Selected Metropolitan Areas: April, 1977 - Adjusted [1]

Area	Labor Force	Unemployment	
		Number	Percent
Michigan	4,017.5	301.6	7.5
Detroit Area[1]	1,781.1	133.5	7.5
Flint Area[1]	234.9	16.4	7.0
Grand Rapids Area	278.6	15.0	5.4

[1]SMSA data adjusted to reflect only the tri-county area in Metropolitan Detroit figures and to add Lapeer county to the Flint area figures. Thus, Detroit Area = Wayne, Oakland, and Macomb counties; while Flint Area = Genesee, Shiawassee, and Lapeer counties; and Grand Rapids Area = Kent and Ottawa counties.

Source: U.S. Bureau of Labor Statistics. Employment and Earnings, Vol. 24, No. 7, July, 1977. Table E-1.

TABLE 4:

Employees on Non-agricultural Payrolls for State and Selected Metropolitan Areas by Industry Division: April, 1977 - Adjusted[1]

Industry	Michigan		Detroit Area[1]		Flint Area[1]		Grand Rapids Area	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
TOTAL	3,356.2	100.0	1,554.3	100.0	165.0	100.0	234.8	100.0
Mining	11.7	0.3	1.1	0.1	----		----	
Construction	114.3	3.4	51.6	3.3	4.8	2.9	8.8	3.7
Manufacturing	1,086.0	32.4	525.0	33.7	71.6	43.4	80.9	34.5
Wholesale & Retail Trade	685.3	20.4	305.6	19.7	32.2	19.5	54.4	23.2
Finance, Ins. & Real Estate	137.6	4.1	75.3	4.8	4.7	2.8	8.5	3.6
Services	563.9	16.8	283.9	18.3	21.7	13.1	43.1	18.4
Government	612.6	18.3	237.5	15.3	24.6	15.0	29.6	12.6
Transportation & Public Utilities	144.7	4.3	74.3	4.8	5.5	3.3	9.5	4.0

[1]SMSA data adjusted to reflect only the tri-county area in Metropolitan Detroit figures and to add Lapeer County to the Flint area figures. Thus, Detroit Area = Wayne, Oakland, and Macomb counties; while Flint Area = Genesee, Shiawassee, and Lapeer counties; and Grand Rapids Area = Kent and Ottawa counties.

Source: U.S. Bureau of Labor Statistics. Employment and Earnings, Vol. 24, No. 7. July, 1977, Table B-8.

TABLE 5:

Major Occupation of Employed Persons by Selected Industry Group: 1970 Michigan Data

Local Area	Selected Health Service Industry			
	Hospitals		Health Services, Except Hospitals	
	Number	Percent	Number	Percent
Detroit Area				
Total Employed	58,081	100.0	31,561	100.0
Prof., Tech., & Kindred	19,807	34.1	11,591	36.7
Clerical & Kindred	10,610	18.3	5,845	18.5
Service Workers	23,797	41.0	12,174	38.6
Flint Area				
Total Employed	6,728	100.0	4,293	100.0
Prof., Tech., & Kindred	2,003	29.8	1,400	32.6
Clerical & Kindred	1,040	15.5	754	17.6
Service Workers	3,287	48.9	1,785	41.6
Grand Rapids Area				
Total Employed	6,895	100.0	4,932	100.0
Prof., Tech., & Kindred	2,393	34.7	1,638	33.2
Clerical & Kindred	1,029	14.9	707	14.3
Service Workers	3,017	43.8	2,175	44.1

Source: U.S. Bureau of Census, Census of Population: 1970, Detailed Characteristics. Final Report PC(1)-D24 Michigan. (1972) Table 180.

TABLE 6:

Detailed Breakout of Health Occupations by Residence, 1970 Michigan Data

Occupations by Major Classification	Detroit Area		Flint Area		Grand Rapids Area	
	Number	%	Number	%	Number	%
Professional, Technical & Kindred Workers						
Registered Nurses, Dieticians & Therapists TOTAL	16,234	100.0	1,921	100.0	2,339	100.0
Dieticians	775	4.8	92	4.8	67	2.9
Registered Nurses	13,955	85.9	1,682	87.6	2,128	91.0
Therapists	1,504	9.3	147	7.6	144	6.1
Health Technologists & Technicians TOTAL	5,644	100.0	646	100.0	602	100.0
Clinical Laboratory Technologists & Tech.	2,421	42.9	229	35.4	238	39.5
Dental Hygienists	480	8.5	56	8.7	42	7.0
Health Record Technologists & Tech.	1,237	21.9	146	22.6	99	16.4
Therapy Assistants	61	1.1	----	----	11	1.8
Health Technologists & Tech. N.E.C.	1,235	21.9	168	26.0	184	30.6
Service Workers, Except Private Household						
Health Service Workers TOTAL	26,983	100.0	3,922	100.0	3,846	100.0
Dental Assistants	2,396	8.9	146	3.7	211	5.5
Health Aides	4,408	16.3	510	13.0	384	10.0
Health Trainees	268	1.0	29	0.7	31	0.8
Lay Midwives	7	0.1	6	0.2	----	----
Nursing Aides, Orderlies & Attendants	14,600	54.1	2,123	54.1	2,168	56.4
Practical Nurses	5,300	19.7	1,108	28.3	1,052	27.3

Source: U.S. Bureau of Census, Census of Population: Detailed Characteristics. Final Report PC (1)-D24 Michigan (1972). Table 171.

TABLE 7:

Nativity by Age and Sex; 1970 Michigan Data by Area

Age Category	STATE			DETROIT AREA			FLINT AREA			GRAND RAPIDS AREA		
	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female
Under 19	3,590	1,822	1,767	1,668	844	823	215	110	106	226	115	111
PERCENT	40.5			39.7			43.4			41.9		
20 - 39	2,245	1,083	1,162	1,047	498	555	130	63	68	134	64	71
PERCENT	25.3			24.9			26.3			24.9		
40 - 64	2,285	1,114	1,171	1,143	555	587	117	58	59	131	63	69
PERCENT	25.7			27.2			23.7			24.3		
65 & over	755	328	427	342	148	192	32	14	19	48	19	28
PERCENT	8.5			8.2			6.6			8.9		
[1]TOTAL all ages	8,875	4,347	4,528	4,200	2,047	2,152	496	244	252	539	261	279
PERCENT	100.0			100.0			100.0			100.0		

[1]The sum of the parts do not necessarily equal the total because of rounding.

Source: U.S. Bureau of Census, Census of Population: 1970, Detailed Characteristics. Final Report PC(1)-D24 Michigan. U.S. Government Printing Office, Washington, D.C. 1972. Table 148.

TABLE 8:

Vital Statistics on Health, 1974 - 1977 by Area

Health Care Providers	Detroit Area[1]	Flint Area	Grand Rapids Area
Physicians (1974)[2]	6,783	585	763
Rate per 100,000[3]	152.6	113.2	138.0
Surgeons (1976)[4]	1,242	132	196
Rate per 1,000[5]	3.4	3.4	3.8
Hospital Data:[6]			
Total Hospitals (1977)	71	9	11
Total Beds	18,435	2,646	2,751
Rates per 100,000	384	447	475
Skilled Nursing Facilities[7]			
Total Number (1977)	95	12	10

[1]Detroit area figures include the tri-county area only.

[2]Source: U.S. Bureau of Census. Statistical Abstract of U.S.: 1975, (96th Edition) Washington, D.C., 1975.

[3]Rate per 100,000 located in area, July 1, 1973.

[4]Source: Michigan Health Council. Report of Michigan Physicians by County, 1977.

[5]Rate per 1,000 Medicare beneficiaries only (1976).

[6]Source: Michigan Department of Public Health. Licensure Report, 2-17-77.

[7]Source: Blue Cross and Blue Shield of Michigan. List of Blue Cross Participating Nursing Homes, March, 1977.

III. CONSULTANTS

A. Qualifications

A second and third opinion consultation will be arranged with a participating program consultant whose specialty is appropriate to the beneficiary's condition. Consultants in this program must be practicing in the experimental area and be either a Doctor of Medicine (M.D.) who is a Board Certified Surgical Specialist or a Doctor of Osteopathic Medicine (D.O.) who is a Certified Surgical Specialist. In addition, Oral Surgeons (D.D.S.) must be Board Certified in Oral Surgery and Podiatrists (D.P.M.) must be either Board Certified by the American Board of Podiatric Surgery or be Fellows of the American College of Foot Surgeons.

All program consultants must have professional liability coverage and must sign the Participating Agreement and the Addendum (Appendices 3 and 4). The consultant's signature on the Participating Agreement indicates his/her willingness to render second opinion consultations for Auto members. The Addendum is a document which the consultant signs to extend his/her services as a program consultant to cover the MSSOP and other second opinion programs administered by BCBSM. The purpose of requesting current and prospective consultants to sign both documents is to enable them to serve as program consultants in all BCBSM second opinion programs. To date, 253 consultants have signed both documents. BCBSM is still awaiting response from 451 eligible surgeons.

In addition to agreeing to the BCBSM position on professional liability coverage (Appendix 5) and signing the agreements, the consultant must agree to comply with the terms and conditions contained in the Consultant's Manual (Appendix 21). This manual is sent to all those who have expressed interest in serving as a program consultant. It contains information and guidelines pertinent to the functions of a consultant, such as, a list of consultant responsibilities and procedures for submitting claims.

B. Recruitment

Consultants to this program are recruited either through letters of invitation mailed to all eligible surgeons in the Tri-County area, or through the assistance of a local specialty society. To date, letters of invitation have been mailed to prospective consultants. Refer to Table 9, page 28 for a breakdown of the recruitment effort, and to Appendices 6-9 for letters of invitation and enclosures.

Currently, 164 M.D.s, 40 D.O.s, 15 Oral Surgeons (D.D.S.) and 6 Podiatrists (D.P.M.) have signed the Participating Agreement with Addendum. For a further breakdown of program consultants from the various specialties and counties, refer to Table 10, page 29. A second recruitment effort can be made should the volume of second opinion appointments warrant additional consultants.

C. Responsibilities

Program consultants must agree to the following:

- They and their associates shall not render the surgical service to beneficiaries for whom they have provided a second/third opinion.

- They shall personally examine the beneficiary, render the second/third opinion, discuss the recommendation with the beneficiary and complete the Consultant's Report for the BCBSM Referral Center.

- They shall refer the beneficiary back to the care of the original physician. However, if the beneficiary should specifically request it, referral may be made to another physician barring conflict of interest.[25] If referral to another physician is made, the consultant must document the referral on the reverse side of the Referral Center's copy of the Consultant's Report, i.e. the Consultant must indicate the beneficiary requested the referral and must give the name, address and specialty of the physician.

- They shall accept the consultation fee set forth by the program as payment in full for their professional services with no additional charges to the beneficiary.

- They shall schedule the consultation appointment so as not to delay a beneficiary's scheduled hospitalization.

- They must inform the Referral Center by telephone if they cannot see the beneficiary on the scheduled appointment date, or if the beneficiary fails to keep the appointment as scheduled.

- They must not contact the beneficiary's First Opinion Physician (F.O.P.) to obtain information or to discuss the outcome of the consultation if the beneficiary specifically requests that the F.O.P. not be informed of the second/third opinion consultation. Should the consultant find it advisable to confer with the beneficiary's F.O.P., the beneficiary's consent must first be obtained and this consent should be documented on the reverse side of the Referral Center's copy of the Consultant's Report.

---

[25] For this program, conflict of interest is defined as referral of patients to physicians in a group, association, partnership, or professional corporation in which the consultant has any financial or family interest.

- They shall rely on existing laboratory and x-ray reports, ordering diagnostic services only when absolutely necessary.

- They, to the extent possible, should perform any diagnostic services at their office or use the services of an independent lab/x-ray facility certified by Medicare, to ensure that the beneficiary's deductible and copayment will not be applied, requiring out-of-pocket expenses.

- They will advise a beneficiary, who must be hospitalized for testing in order to provide a second/third opinion, that only the consultation is paid by the second opinion program and that the hospitalization is subject to normal Medicare benefits and limitations for inpatient stays.

- They will advise the beneficiary if any needed tests are not payable by Medicare, and hence, not payable by this program so that the beneficiary will understand that the tests are to be paid by the beneficiary.

- They will advise the beneficiaries making their own appointments (self arranged appointments) that they can have the consultation covered by the demonstration program if they contact the BCBSM Referral Center. Further, the consultants must agree that they will not submit their claims until they have received, completed, and mailed the Consultant's Report to the BCBSM Referral Center for patients who then call the Referral Center for coverage of this appointment.

- They must agree to keep all information relating to the program confidential in accordance with the provisions of the Privacy Act of 1974 (Public Law 93-579) as prescribed in 5 U.S.C.a(e)4.

- They are required to give 30 days notice to BCBSM if they wish to resign from participation as a program consultant. They are required to complete all scheduled appointments for the Medicare Surgical Second Opinion Program before the effective date of resignation.

TABLE 9:

Results of Consultant Recruitment as of 7/31/78

Category	WAYNE					OAKLAND					MACOMB					GRAND TOTAL				
	M.D.	D.O.	D.D.S.[1]	D.P.M.[2]	TOTAL	M.D.	D.O.	D.D.S.[1]	D.P.M.[2]	TOTAL	M.D.	D.O.	D.D.S.[1]	D.P.M.[2]	TOTAL	M.D.	D.O.	D.D.S.[1]	D.P.M.[2]	TOTAL
Invitations Mailed	390	20	35	5	450	227	23	31	2	283	51	19	9	1	80	668	62	75	8	813
Responses Rec'd. (as of 7/31/78)	99	13	6	5	123	106	19	9	1	135	13	8	6	0	27	218	40	21	6	285
Positive[3]	83	12	6	4	105	95	19	7	1	122	13	7	6	0	26	191	38	19	5	253
Negative[4]	16	1	0	1	18	11	0	2	0	13	0	1	0	0	1	27	2	2	1	32
Invitations Returned[5]	54	0	1	0	55	20	0	0	0	20	2	0	0	0	2	77	0	0	0	77
Responses Outstanding[6]	237	7	28	0	272	101	4	22	1	128	36	11	3	1	51	373	22	54	2	451

[1] Refers to Board Certified Oral Surgeons only.

[2] Refers only to Podiatrists whose names were provided to BCBSM by the Podiatric Coordinator working closely with the local Podiatric Association.

[3] Responses from doctros indicating interest in serving as a program consultant.

[4] Responses from doctors expressing refusal to serve as a program consultant.

[5] Letters of invitation returned due to doctors relocating without leaving forwarding addresses.

[6] Letters of invitation which have not been answered.

TABLE 10:

Participating Consultants by Specialty and by County (As of 7/31/78)

SPECIALTY	WAYNE				OAKLAND				MACOMB				GRAND TOTAL			
	M.D.	D.O.	OTHER	TOTAL	M.D.	D.O.	OTHER	TOTAL	M.D.	D.O.	OTHER	TOTAL	M.D.	D.O.	OTHER	TOTAL
General Surgery	24	3	-	27	14	12	-	26	7	4	-	11	45	19	-	64
Otorhinolaryngology	6	0	-	6	7	0	-	7	0	0	-	0	13	0	-	13
Obstetrics - Gynecology	20	1	-	21	27	1	-	28	3	4	-	7	50	6	-	56
Ophthalmology	14	2	-	16	12	0	-	12	1	2	-	3	27	4	-	31
Orthopedic	6	1	-	7	5	4	-	9	0	0	-	0	11	5	-	16
Plastic Surgery	1	0	-	1	1	0	-	1	0	0	-	0	2	0	-	2
Proctology	0	3	-	3	0	0	-	0	1	0	-	1	1	3	-	4
Thoracic Surgery	4	1	-	5	0	0	-	0	2	0	-	2	6	1	-	7
Urology	1	0	-	1	3	0	-	3	0	0	-	0	4	0	-	4
Neurological	2	1	-	3	0	1	-	1	0	0	-	0	2	2	-	4
Cardiovascular	0	0	-	0	2	0	-	2	1	0	-	1	3	0	-	3
Podiatric Surgery (D.P.M.)	-	-	4	4	-	-	1	1	-	-	1	1	-	-	6	6
Oral Surgery (D.D.S.)	-	-	4	4	-	-	8	8	-	-	3	3	-	-	15	15
TOTAL	78	12	8	98	71	18	9	98	15	10	4	29	164	40	21	225

IV. CONSUMER/PROVIDER EDUCATION AND MARKETING

A. Public Relations Objectives

The public relations objectives of the Medicare Surgical Second Opinion Program (MSSOP), over the life of the demonstration program, are to:

- Inform Medicare recipients about the program and the specific difference from the nationwide second opinion effort.
- Utilize channels of communication which will facilitate acceptance of MSSOP publicity information among older adults.
- Involve social, service, community, municipal, governmental and gerontological organizations in the communication process and program.
- Stimulate inquiries from older adults to the Referral Center established for the second opinion surgery program.
- Inform providers of health care (physicians, hospitals, nursing homes, etc.) of the MSSOP.

B. Audience

Second/third opinions will be available to Medicare beneficiaries residing in the Detroit Tri-County area. In addition to the Medicare beneficiaries, various organizations and agencies will also be included in the publicity efforts directed at the target population.

1. Current Medicare Recipients

The number of the target audience, estimated for the Tri-County are:

o Wayne County	275,000
o Oakland County	68,000
o Macomb County.	33,000
TOTAL	376,000

This total of 376,000, althouth it represents a sizeable group to reach and motivate, is the core of a larger population which must hear the Blue Cross and Blue Shield of Michigan's message.

2. Future Medicare Recipients

In addition to the 376,000 now age 65 years or more, there is a small but sizeable population of persons who will reach this plateau during the life of the program -- perhaps as many as 25,000 more in the Tri-County area.

3. Organizations and Agencies

To the total Medicare beneficiaries will be added the persons who are principal leaders in meeting the social and health needs of older adults.

a. Consumer Agencies

The two Agencies on Aging have responsibility for coordinating activities of a large number of organizations providing services to older adults. Through their cooperation and leadership, BCBSM will strive to reach these many groups assisting Medicare beneficiaries and advise these eligible beneficiaries about the program. Others include clergy, heads of retirement groups, block club officers, state, county and municipal department heads, non-profit social service agencies and others who will be described later in this section. Their numbers may exceed 2,000.

Most of the heads of block clubs are in major cities, such as Detroit, Mt. Clemens, Royal Oak and Pontiac. In Detroit alone, block clubs and community councils number approximately 1,600; they are vital because many of them offer programs for older adults or are operated by senior citizens.

In addition to block clubs, there are senior citizen clubs. In Detroit alone there are 90 of them. Others are located in Belleville, Dearborn, Hazel Park, Inkster, Livonia, Pontiac, Redford, Romulus, Royal Oak, Southfield, Taylor and Westland. All these cities are outside Detroit, yet within the experimental area for the MSSOP.

Also included are Social Security Administration District Offices, senior housing units, BCBSM District Offices, BCBSM groups with retirees, and adult education programs.

b. Providers

Added also to the total audience are physicians, hospital and nursing home administration -- to inform them of the availability of the program and to educate them fully on the mechanisms and workings of it. A second goal would be to encourage providers to lend full cooperation in assisting BCBSM to educate their publics.

C. Reaching the Audience

The program outlined here relies greatly and justifiably on the cooperation of many of the groups, services and institutions noted in Item B.3. preceding. It is believed that publicity alone regardless of whether it appears in the general media or specialized media cannot deliver the results which either Blue Cross and Blue Shield of Michigan or the U.S. Department of Health, Education and Welfare expect. This is largely true because of the very nature of the target audience, some of whose characteristics may include:

- Suspicion of health-related services which involve personally unfamiliar contacts, situations or institutions.
- Lack of clear understanding about Medicare's function and what it covers.
- Lack of information about what is covered by Blue Cross and Blue Shield of Michigan and what is not.

Each of these points may hinder communication and nearly guarantee that the MSSOP will be hard pressed to reach its goal unless special considerations are made. The special considerations made involve the development of a program which relies on the familiar and the credible, in the perception of the target audience. For the sake of this program, "the familiar and the credible" are the groups, services and individuals noted earlier. These groups and organizations, representing the broadest possible range of interests and services, are classified and described on Table 11 pages 33-36.

D. Establishing a Link of Participation

As noted earlier, it is BCBSM's intention to place a good deal of reliance on using the organizations and agencies classified on Table 11, pages 33-36 as the means of reaching up to 400,000 Medicare beneficiaries within the next three years. Generally, the organizations communicate with older adults by using several means. They include:

- Special publications and newsletters.
- Organization meetings.
- Special Event Programs.
- General news media.

In all cases, the communications help the agencies serve seniors. BCBSM expects that, since the MSSOP offers services which benefit seniors, most would be willing to relay information about the program directly to seniors if it is provided in a readily usable form.

TABLE 11:

Major Categories of External Agencies and Organizations for MSSOP Publicity

Classification/Category	Description/Definition
1. Government Agencies/ Departments	Agencies, departments or organizations directly administered/fully supported by either the Local, State or Federal Government. They include such agencies/departments as the County Departments of Social Services, the County Health Departments, Area Agencies on Aging, Senior Citizen Departments of the cities, etc.
2. Housing	Residences for senior adults which are affiliated with major religious denominations and charitable institutions, or which are publicly or privately financed. Examples are the approximately 30 state-financed housing developments in the Tri-County area, or the approximately 12 residences run by church organizations and charitable institutions, such as the Jewish Home for the Aged.
3. Senior Citizen Clubs/ Retirement Organizations	Social, business/professional, civic and cultural groups whose members are mainly senior adults. Examples are the numerous Senior Citizen Clubs (more than 90 in Detroit alone), National Council of Senior Citizens, the American Association of Retired Persons, Service Corps of Retired Executives, National Retired Teachers Association and the Archdiocesan Council of Senior Citizens.

TABLE 11 (Continued):

Major Categories of External Agencies and Organizations for MSSOP Publicity

Classification/Category	Description/Definition
4. Specialized Health Organizations	Organizations providing specialized health services and information to the community at large. Such organizations are the American Diabetes Association, the Arthritis Foundation, Detroit Hearing and Speech Center and the Michigan Cancer Foundation.
5. Churches and Church Related Organizations, (excluding luncheon sites and senior citizen clubs)	Includes the Lutheran social service organizations, the Archdiocesan social service organizations and many others which can be identified through the Christian Communication Council of Metropolitan Detroit Churches.
6. Educational Institutions	Includes the 3 major universities in the area, plus several colleges and 2 year community colleges which offer a variety of programs for and about senior adults. A specific example is the Dept. of Gerontology at Wayne State University.
7. Food and Friendship Sites (Nutrition Sites)	Includes the numerous locations throughout the Tri-County area which provide meals and/or nutritional services to senior adults. The sites are in locations such as local schools, community centers, churches, and senior citizen housing.

TABLE 11 (Continued):

Major Categories of External Agencies and Organizations for MSSOP Publicity

Classification/Category	Description/Definition
8. Veterans Organizations	Includes organizations such as the American Legion and the Veterans of Foreign Wars whose members are mainly military veterans.
9. Ethnic Oriented Services/ Organizations	Includes numerous organizations whose focus is on the many ethnic groups in the area. For example, the International Institute of Metropolitan Detroit, the American Indian Services, the Arab Community Center for Social Services, Latin Americans for Social and Economic Development (LASED), NAACP, etc.
10. Libraries	Includes the Detroit Public Library's service to Shut-ins and retirees, and the Wayne County Federated Library System which provides library services for the blind and physically handicapped.
11. Recreation and Multi-purpose Centers	Includes the many centers throughout the Tri-County area which provide recreational programs and other activities for senior adults, e.g. Belle Isle Casino, Downtown Senior Citizens Center and the Pontiac Multi-purpose Center.

TABLE 11 (Continued):

Major Categories of External Agencies and Organizations for MSSOP Publicity

Classification/Category	Description/Definition
12. Miscellaneous Agencies/ Organizations	Additional agencies/organizations/ groups not mentioned in the above categories but which provide service or have contact with senior adults, e.g. Independent Support Service, Hazel Park/Ferndale Chore Service and the Adult Service Centers, Inc.

NOTE: At this writing, BCBSM has identified over 700 agencies/ organizations/groups which are possible contacts to help publicize the MSSOP, and this list does not include the individual block clubs which are reached through mailings by the City of Detroit. The City department responsible for block club mailings has agreed to distribute a news release on the program.

The link, then, with those groups and organizations will be to provide information which allows them to reach their own goal of offering service to seniors. Their roles in the MSSOP will be active, but not so active that their own projects and activities suffer.

Also, in an effort to reach all the Medicare beneficiaries eligible to participate in the demonstration program, the U.S. Senators from Michigan, the U.S. Congressmen from Wayne, Oakland and Macomb counties and Michigan State Legislators will be contacted and requested to help publicize the MSSOP. They will be requested to publish a news release, supplied by the program, in their newsletters to their constituents. This would enable them to demonstrate what the Federal Government is doing. This news release would reach people both under 65 years old and over 65 years old, and that could be helpful also. Medicare beneficiaries' sons and daughters could then be informed of the MSSOP and so advise their parents. Refer to Appendix 10 for the news release to be provided to the officials.

Finally, besides the emphasis on other organizations and agencies for the communication of the program, BCBSM will also utilize other more direct methods to reach the target population. These include:

- o A program envelope stuffer included in the regular mailings to new BCBSM Complementary subscribers (i.e. those obtaining coverage supplementing Medicare),
- o TV/radio public service "spot" announcements,
- o News releases and news media interviews.

E. Using Organization Support and Other Resources

The organizations described earlier may be asked to assist the program by providing the following services:

- o Endorse the program.
- o Demonstrate how to use the program.
- o Make the program known as one which serves the interests of seniors during organization meetings, special programs, in newsletter articles and in editorials.
- o Schedule speaker's presentations for organization meetings.
- o Publish information releases in organization newsletters and other publications.
- o Distribute flyers with publications or to members during organization meetings and programs attended by older adults.

- o Use slide presentations for organization meetings and other special activities.

- o Display posters and other visual materials in headquarters or offices.

- o Give members basic particulars on the program, especially during face-to-face meetings.

- o Emphasize the Referral Center number.

None of these functions will burden any given organization or institution if it is given the wherewithal to do a solid communications job.

F. Coordination of Organization Support

An advisory committee has been established to assist in opening valuable channels of communications to older adults throughout the Tri-County area, referred to as the Medicare Beneficiary Education Advisory Committee.

The Committee is comprised of approximately 15 leaders from organizations providing services, coordinating services, or providing social outlets for older adults. Their charge is to lend guidance, knowledge and support to be used in presenting the program both prior to its announcement and after its implementation.

It is the expectation that they will also identify established channels of communication within the community which provide established training sources, methods of distribution for printed materials, as well as informational and educational outlets.

G. Public Relations Materials Needed By Supporting Organizations

Various public relations materials will be available prior to the MSSOP's formal public announcement two or three weeks before the onset of the program.

1. Program Identity

To help various groups fulfill the public relations functions of the MSSOP, certain kinds of resource materials will be needed. These materials -- as communications devices -- will have an appearance of their own to dramatically distinguish MSSOP mailings from others which older adults receive from Blue Cross and Blue Shield of Michigan, Medicare, and the Social Security Administration and elsewhere; therefore the MSSOP will have its own simple "corporate name and signature", both of which may help establish the identity of the program in the perception of older adults. Refer to Appendix 11 for the letterhead showing the program's identity symbol.

2. Slide Film Program

A slide film will be developed describing the program. It will be available with a pulse sound tape for use on appropriate carousel equipment. A numbered script indicating where to change the slide will also be provided to allow the individual presentor a choice. An opening and closing speech text will also be provided.

The users of the script program will provide their own projection equipment. Instructions on how to use the pulse tape and the necessary equipment required will be provided.

3. Brochures

The brochure (Appendix 12) will briefly outline the functions of the MSSOP but devote most of its contents to a step-by-step run through outlining how to properly use the program. A question and answer format will be used.

Brochures will be distributed to a multitude of support organizations for use at the training/education sessions, to hospitals and to doctors' offices for use in their "take one" pocket bearing counter stands and to BCBSM retiree groups and others.

4. Posters

The poster (Appendix 13) will contain basic program information and the telephone number for the Referral Center. The poster will be displayed in places such as community centers, schools, churches, senior citizen residences, public areas in hospitals and doctors' offices, and SSA offices in the Tri-County area.

5. Envelope Stuffers

The envelope stuffer (Appendix 14) will be printed for mailing to specific audiences. It will be used as a reinforcement. The copy content will provide basic program information, Referral Center telephone number and specific instructions.

6. Wallet Card

The Wallet Card (Appendix 15) will be a reinforcement piece. One side will provide minimal program information, but will have printed in large numbers the Referral Center telephone number. On the other side -- a health emergency card will be provided for individuals to fill out, listing all pertinent health information.

7. Newsletter

A one page newsletter (printed on two sides) will be issued as needed for organization heads and community leaders. It will discuss aspects of the Second Opinion Surgery Program in lay terms. The newsletter will be an additional selling tool and a continuing means of fostering communications on the program.

8. Informational Announcement Letters

Informational announcement letters (Appendices 16 to 18) will be sent to area doctors, hospital and nursing home administrators and other health care related agencies and organizations, such as the Area Agencies on Aging. They will contain information on the MSSOP and will solicit assistance in the effort to publicize the program. Attached to the letter to health agencies will be a news release, see Item 9, which they can publish in their newsletters, plus a "Needs" survey (Appendix 19) to order program materials. The letter to area doctors will also request their cooperation in providing necessary medical information about patients to be used by the program consultants.

9. Suggested News Release

This news release (Appendix 10) will be sent to the elected officials representing the residents of the Detroit Tri-County area as a suggested topic for inclusion in their mailings to constituents. Also, it will be used for health agencies and senior citizen organizations to place in their newsletters, and for release to various other sources including BCBSM publications.

10. Comparison Chart

A comparison chart will be developed and made available to groups who request basic information on both the MSSOP and the nationwide Medicare second opinion effort.

11. Program Description Booklet

A booklet describing the MSSOP (Appendix 20) will be printed and made available as an information source for: physicians in general; program consultants; other professionals and providers of health care; representatives of health care oriented organizations and groups interested in second opinion programs; and agencies, organizations and groups involved in services for older adults.

12. Consultant's Manual

A Consultant's Manual (Appendix 21) describes the terms and conditions to which a program consultant must agree. This manual will be sent to all doctors who sign an agreement to participate as consultants for the MSSOP. In addition, it will be sent to doctors

who express a willingness to participate but wish more information on the responsibilities of a program consultant. It will be available also to other professionals and agency heads who may find a need for information contained in the Consultant's Manual.

13. Background Paper

If the need arises, BCBSM may develop a background paper dealing with the history of second opinion programs and giving a brief discussion on the differences between the other BCBSM second opinion programs, the MSSOP, and the regular Medicare second opinion benefit. This can be an expansion of the comparison chart mentioned in Item 10, preceding.

14. Speakers

BCBSM will make available to groups a trained staff from within the company to speak on the MSSOP. Further, the trained staff will be available to work with and train outside groups, government agencies and community leaders so that they can, in turn, speak knowledgeably to others on the MSSOP. The Medicare Beneficiary Education Advisory Committee and the target list will be most helpful in identifying those groups most capable of handling their own "outreach" second opinion publicity.

Whether the speaker is a BCBSM staff member or a trained leader from one of the organizations, agencies or groups, BCBSM will provide the educational materials needed by the speaker. These will be the slide presentation, script, speech text (i.e. introductory and closing statements), brochures and wallet cards.

15. Phone Access

The Referral Center will have its own well-circulated telephone number. However, since this line may often be busy, special telephone numbers which community organization leaders, social agency heads and other opinion leaders may use to get answers to questions about the program will be made available. These numbers will be communicated to leaders by direct mail and by inclusion in the Program Description booklet.

16. "Needs" Survey

The program will make available to various agencies, groups and organizations a Second Opinion Services Request form on which they can indicate the MSSOP publicity materials and/or services they need to reach out to eligible beneficiaries in the experimental area (Appendix 19).

H. Distribution of Materials

The various sectors of the target population for the MSSOP publicity effort and the type of printed, audio/visual and media-related materials they will receive are listed in this segment.

1. For Organization Leaders

Organization leaders will receive:

- Announcement Letter -- to announce the program.
- Brochures -- for distribution to members of their organizations.
- Envelope Stuffers -- sample included in information/media kit.
- Program Description Booklet -- a brief, semi-technical description of the MSSOP.
- Posters -- for display in their agencies, organizations, etc.
- Slide Presentations -- shown as part of original orientation.
- "Needs" Survey -- for use in ordering MSSOP publicity materials and for other related needs.
- News article/release.
- Newsletters -- to keep leaders updated and informed.
- Wallet Cards -- sample included in information media kit.
- Information/Media Kits -- provided to leaders attending the formal announcement of the MSSOP to the community.

2. For Older Adult Audiences

The thrust of the publicity effort is to reach the Medicare beneficiaries in the Tri-County area and make them aware of the program and their eligibility to obtain a second opinion. The following pieces of publicity materials will be used to reach the Older Adult audience:

- Brochures -- question and answer format, obtained through organizations, hospitals, doctors' offices, etc.

- o Wallet Card -- obtained through organizations, hospitals, doctors' offices, etc. Second opinion information printed on one side, and the beneficiary medical I.D. card on the reverse side.

- o Envelope Stuffers -- will be mailed as reinforcement to specific identified audiences.

- o Slide Presentation -- will be used as educational tool through organizations, agencies, etc.

- o Public Information -- will be provided through the media, organization publications, and by newsletters from elected officials.

3. For Health Care Provider Audiences

The following materials will be made available to health care providers who wish to assist in the efforts to make beneficiaries aware of the MSSOP. They are:

- o Program Description Booklet -- for doctors, hospitals, nursing homes and other providers of health care who request the booklet.

- o Consultant's Manual -- for program consultants and prospective program consultants.

- o Letters of Announcement -- will be mailed to individual doctors in the Tri-County area and to hospital and nursing home administrators.

- o "Needs" Survey -- for providers to use when ordering brochures and posters for display.

4. For U.S. Congressmen, Senators and State Legislators

Elected officials whose constituents live in the Tri-County area will be requested to assist in publicizing the MSSOP. A suggested news release will be provided to them with a request that they disseminate the information to their constituents.

5. For Trainers

The following materials will be provided to MSSOP trainers:

- o Slide Presentation and Pulse Sound Tape -- will be used first to train leaders who, in turn, will inform the organization members.

- o Numbered Script -- will be used as an alternative to using pulse tape with slide presentation.

- o Second Opinion Background Paper (if it will be helpful) -- will provide the history of second opinion programs and a brief explanation of the differences between the other BCBSM second opinion programs, the MSSOP, and the regular Medicare Second Opinion benefit.

- o Script and Equipment Explanation Sheet -- will explain the use of the numbered script and the equipment required to use the pulse tape with slides.

- o Introductory and Closing Speech -- will be used before and after the slide presentation, as needed.

6. For Media/Information Kits

One each of the following publicity materials will be included in a two-pocket folder and will be presented to media representatives and attendees at the formal introduction of the MSSOP to the community:

- o Brochure

- o Poster

- o Wallet Card

- o Program Description Booklet

- o Various news releases

- o Envelope Stuffers

- o "Needs" Survey

- o Background paper (if available).

I. Provider and Professional Relations Support Activities

Some aspects of the publicity effort discussed so far, and others noted subsequently will have an impact on BCBSM Professional Affairs and Provider Affairs. They will provide assistance and counsel for the following activities:

- o Seeking aid from medical and health organizations to disseminate MSSOP information to professionals.

- o Determining the feasibility of displaying publicity materials in hospitals and in doctors' offices.

- o Using existing BCBSM publications directed to hospitals, doctors and other health professionals as a means to describe the program.

- o Training assistance.

J. Start-up Activities/Formal Introduction of the MSSOP

Like other programs requiring responses from some segment of the public, the MSSOP requires a well-planned public introduction that will help earn attention, recognition and acceptance. A high-visibility introduction program will be held a few weeks prior to the implementation date of the MSSOP. It is designed to:

- o Formally reveal to the news media, details about the program and its intended audience.

- o Formally reveal details of the program to leaders of principal senior citizen groups, social service agency heads and other key opinion leaders who deal with older adults, to secure their cooperation in publicizing the MSSOP.

The formal introduction of the MSSOP will be held in the BCBSM Auditorium and at the BCBSM courtyard. It will be divided into three parts:

- o The first part will consist of a press conference where details of the MSSOP will be revealed by principal spokespersons.

- o The second part of the program will consist of a repeat of the announcement especially for senior group leaders, social service agency heads, civic organization presidents and others who provide services for older adults. This portion of the program, by giving personal attention to the leaders who must relay information about the MSSOP to 400,000 seniors, is vital to earning community-wide cooperation.

- o The third part of the program will consist of a special event luncheon program sponsored by the BCBSM Community Relations Department.

1. Press Conference

As stated, the first part of the program introduction is to reveal details about the Medicare Surgical Second Opinion Program to the news media. To achieve this objective, BCBSM will hold a Press Conference at the BCBSM auditorium in mid-July, 1978. The Press Conference will be held in the morning opened by Richard Whitmer, Executive Vice President of Legal, Governmental and Public Affairs. Louis F. Hayes, M.D., the Project Director for the demonstration

program will describe the program to the Press and introduce the principal speaker, Robert Derzon, Administrator, Health Care Financing Administration, U.S. Department of Health, Education and Welfare. A press kit will be provided to the news media.

2. General Information Meeting and Orientation

The second part of the program's formal introduction is to reveal details about the MSSOP to leaders of principal senior citizen groups, social service agency heads and other key opinion leaders who deal with older adults, in order to secure their cooperation. This meeting will be held at the BCBSM auditorium immediately following the Press Conference. The slide presentation describing the operation of the program will be shown and various printed informational materials will be distributed to the attendees. A question and answer period will follow the slide presentation.

3. Special Event Luncheon Program

The final part of the program's formal introduction will be a special entertainment program and box luncheon to further establish good will towards the MSSOP, BCBSM and the DHEW. This event will be held at the BCBSM courtyard and will be sponsored by the BCBSM Community Relations Department at no cost to HCFA.

K. Area Outreach Meetings

Separate meetings for leaders of senior organizations and their members in Wayne, Oakland and Macomb counties will be held and coordinated through the Area Agencies on Aging. The number of meetings required will hinge on several factors, including the variety of organizations in each area, their geographical location, the type of service provided, and so forth. These criteria will be identified with the assistance of the Area Agencies on Aging and the Medicare Beneficiary Education Advisory Committee.

In Detroit, Pontiac, Royal Oak, Mount Clemens and other large population centers within the experimental area, the meetings may be held in conjunction with civic organizations, large retiree organizations, neighborhood associations or other key groups which:

- Are strongly identified with serving older adults.
- May be called upon to provide basic information and advice about the MSSOP.

The area retiree meetings will be held:

- To give the average older adult his/her first direct information about the program from BCBSM representatives.

- o To reinforce the information-giving efforts of the organization leaders.

- o To gauge the progress of the communication program.

The primary need for this section of the program will be manpower, since audio visual materials, speech texts, literature, slides and aids developed for other phases of this program may be used in this ongoing activity. Support manpower will be requested from older adult organizations and BCBSM will supply the necessary publicity materials. Also, a BCBSM employee will present a slide presentation during regular visits to area retiree meetings at no cost to the HCFA.

L. Leadership Training Program

At some point after the implementation of the MSSOP, BCBSM will consider offering a one-day symposium concentrating on health care concerns of the aged. Such a symposium could be designed for leaders of community groups and organizations whose daily activities include providing services for older adults. Resource persons could include representatives of the Area Agencies on Aging, municipalities, universities, professional associations, etc.

By providing the symposium at a modest cost to attendees and/or organizations, BCBSM improves its relations with the community leaders who are the vital link with older adults in the Tri-County area. At the same time, BCBSM could present a discussion on second opinion programs, particularly the MSSOP.

M. Principal Media-Related Activities

The success of any second opinion program depends, to a large extent, on a vigorous and ongoing consumer/provider educational program aimed at reaching the eligible population. In addition to activities planned with various groups, organizations and agencies, the media will be used by BCBSM, to the extent possible, in publicizing the MSSOP. Some of the principal media-related activities anticipated will be:

- o To identify health, professional, scientific and government journals dealing with aging and health to receive press information about the program.

- o To identify opportunities for television/radio broadcast interviews, spaced over the life of the program. Of special interest will be local broadcast programs dealing with the aged and aging, such as those aired over WDET-FM from Detroit and WUOM-FM from Ann Arbor.

- o To provide public service television/radio spot announcements during the program's life.

- o To develop a series of articles on second opinion programs which could be published in weekly newspapers.

- o To identify and compile an extensive mailing list of general media to receive press materials. The list will include a component for civic/community and block club publications, such as Pride Update, the NAACP Newsletter, the Urban League newsletter, church bulletins, block club newsletters, senior club newsletters, YMCA/YWCA publications and so forth.

- o To develop the press conference format announcing the MSSOP and the composition of news releases to be sent at intervals to the media, spaced over the program's duration.

- o To develop press kit materials for the program announcement and subsequent activities. The press kit will be made available for use by editors of the general media.

N. Forward Planning and Ongoing Education

Ongoing educational efforts will be conducted throughout the program's life. Due to the extensive use of external resources such as health agencies, senior citizen organizations, and others, it is not possible to establish a long range schedule of these activities.

It is recognized that these efforts will involve extensive coordination and planning by the project staff in order to maintain visibility. The project staff will develop short range schedules of future educational activities with external organizations, and review the schedule with the Medicare Beneficiary Education Advisory Committee and other community leaders when it is appropriate. Coordination will be needed so that MSSOP special activities do not conflict with other programs for the aged offered by other organizations or institutions, such as the University's Institute of Gerontology. However, by maintaining an awareness of other events pertaining to older adults, BCBSM will be able to:

- o Identify the dates on which the same human resources BCBSM is seeking for the MSSOP outreach meetings will be available.

- o Use these scheduled events on the aged as a means of publicizing the MSSOP.

Further, BCBSM will utilize the educational activities described earlier throughout the program's life and as outlined in the MSSOP Consumer/ Provider Education Plan, Table 12, pages 49-53. Also additional publicity methods will be considered for use at certain periods, such as:

- o Distribution of flyers at supermarkets

- o Distribution of brochures by Scout troops

- o Special displays.

TABLE 12:

MSSOP Consumer/Provider Education Plan

Organizations/Audiences to be Reached	Type of Material Expected to be Used	Method of Dissemination	Proposed Responsibility for Dissemination	Timing of Dissemination	BCBSM Project Support
Leaders of agencies, etc. providing services to older adults (excluding SSA offices)	Announcement letter, brochures, envelope stuffers, Program Description booklet, posters, slide presentation, "Needs" survey, newsletter, wallet cards, information/media kits.	Meetings and mailings	BCBSM will contact leaders and invite them to meetings and/or send informational letters and materials to them.	June, 1978 and ongoing	
SSA offices	Posters, brochures, slide presentations to SSA office staffs for information.	Meetings	BCBSM Staff	May-July, 1978	
Health care providers	Informational letters to physicians and institutional provider administrators.	Mailings of letters	BCBSM	July, 1978	

TABLE 12 (Continued):

MSSOP Consumer/Provider Education Plan

Organizations/Audiences to be Reached	Type of Material Expected to be Used	Method of Dissemination	Proposed Responsibility for Dissemination	Timing of Dissemination	BCBSM Project Support
Health care providers (continued)	Posters and brochures displayed by providers.	Mailing or hand delivery of posters and brochures.	BCBSM	August, 1978 and ongoing	
News Media - daily, weekly papers, special trade/professional publications, etc.	Press articles	Mailings of articles to media for publication	Writing of articles -- BCBSM -- for publication	July, 1978 and ongoing	
Media - radio/TV	Interviews	Radio/TV	BCBSM	Ongoing from start-up	
	Public service spots	Mailings of materials to media (radio/TV)			
Medicare beneficiaries	Brochures, wallet card, stuffers, slide presentation, public information	1. Presentations of slides at senior meetings	1. Mainly to be presented by leaders of senior	1. Ongoing from start-up	1. Delivery of slides and script to organizations for

TABLE 12 (Continued):

MSSOP Consumer/Provider Education Plan

Organizations/Audiences to be Reached	Type of Material Expected to be Used	Method of Dissemination	Proposed Responsibility for Dissemination	Timing of Dissemination	BCBSM Project Support
Medicare beneficiaries (continued)			groups and as needed, presented by BCBSM		their use at a meeting
		2. Displays of posters, brochures, envelope stuffers, wallet cards	2. Senior organizational heads to display materials	2. Ongoing from start-up	2. Delivery of needed materials, as requested
		3. Media	3. Press releases and interviews	3. July, 1978 and periodically during program	3. Writing and release of articles

TABLE 12 (Continued):

MSSOP Consumer/Provider Education Plan

Organizations/Audiences to be Reached	Type of Material Expected to be Used	Method of Dissemination	Proposed Responsibility for Dissemination	Timing of Dissemination	BCBSM Project Support
Medicare beneficiaries (continued)		4. Speakers at meetings	4. BCBSM Speakers and BCBSM Govt. Field Service Representatives	4. August, 1978 and periodically during program	4. BCBSM
		5. Informational letters, company publications, etc. to retiree segments of BCBSM groups	5. BCBSM groups and/or BCBSM	5. July, 1978 and ongoing	5. BCBSM developed materials for groups' use and BCBSM contact to request groups' assistance in announcing to retirees.

TABLE 12 (Continued):

MSSOP Consumer/Provider Education Plan

Organizations/Audiences to be Reached	Type of Material Expected to be Used	Method of Dissemination	Proposed Responsibility for Dissemination	Timing of Dissemination	BCBSM Project Support
Medicare beneficiaries (continued)		6. Suggested news release for constituents	6. U.S. Senators; Congressmen from Wayne, Oakland and Macomb counties, State Legislators	6. Late July, 1978	6. BCBSM drafts of letters
		7. Envelope stuffers in new Complementary members' mailings	7. BCBSM	7. August, 1978 and ongoing to new complementary members	

V. REFERRAL CENTER

A. Location and Administration

The Referral Center for the Medicare Surgical Second Opinion Program is located at the home office of BCBSM in Detroit. It was established in 1977 to administer the second opinion program for Auto members and is currently responsible for all other second opinion programs conducted by BCBSM, the most recent of which is the MSSOP. The Referral Center functions within the Professional Affairs Division of the Corporation.

B. Functions

As the "nerve center" of the MSSOP and all other second opinion programs conducted by BCBSM, the Referral Center's major functions are:

- To arrange referrals with appropriate program consultants for second/third opinions. This involves such activities as eligibility determination, arranging consultation appointments, coordinating the distribution of forms, maintaining records and reports, etc. For additional details on the administrative procedures pertinent to the Referral Center refer to Section VI.

- To interface with internal areas. This includes such activities as providing responses to inquiries from a variety of sources, data collection, and initial screening and approval of claims related to the second opinion programs. For additional details, refer to Section VII.

- To coordinate the second opinion programs by functioning as a central clearinghouse for the MSSOP and other second opinion programs. The Referral Center is also responsible for coordinating and meeting the needs of patients, providers, groups, etc. as they pertain to the MSSOP and other second opinion programs.

C. Operational Staff

The existing Referral Center staff is utilized for the MSSOP, to the extent possible. Initially, they are cross-trained to meet the needs of the MSSOP, and will be supplemented by additional personnel when the volume of calls is sufficient to warrant the addition. If the volume of inquiries and consultation requests warrant an increase in staff beyond the provisions of the contract, approval of the additional staff will be sought from the Contracting Officer. Dr. McCarthy's experience with his second opinion program in New York City indicated that a referral analyst could arrange an average of seventy-five surgical second opinion appointments monthly, in addition to the related follow-up activities.[26]

---

[26] Personal communications with Eugene McCarthy, M.D., Cornell Medical School, New York, New York. March, 1977.

1. Basic Requirements for the Referral Center Supervisor and Analysts

The Referral Center Supervisor and Analysts who are in direct contact with patients and professionals (physicians, Oral Surgeons and Podiatrists) must meet the following basic requirements:

- o They must be Registered Nurses with a minimum of two years active clinical experience.
- o They must possess a demonstrated ability in decision making.
- o They must have at least one year of experience in the health care delivery and financing system, e.g. Medicare program, Medicaid program, third party payor.

2. Existing Referral Center Personnel

At present, there are four employees performing the daily work activities of the Referral Center. They are the:

- o Supervisor, whose main function is to perform direct supervision of the Referral Center, such as monitoring the daily activities and ensuring that the various procedures for operating the Center are properly implemented. In addition, the Supervisor serves as a backup to the Referral Analysts and assists the Administrator.
- o Referral Analysts (2) whose main responsibilities are to arrange second opinion consultation appointments, complete the various operational forms, perform the necessary medical and other coding, contact patients from Auto second opinion program for follow-up surveys, and perform additional activities as delegated by the Supervisor.
- o Utility Clerk, whose responsibilities are to perform all clerical activities which relate to the operation of the Referral Center.

D. MSSOP Project Management

1. Louis F. Hayes, M.D. is the Project Director for the MSSOP as well as Vice President of Professional Affairs, Blue Cross and Blue Shield of Michigan. As Project Director of the MSSOP, Dr. Hayes is responsible for the overall demonstration program.

2. Ann Simpson is the Operational Manager of the MSSOP and also Manager of the Medical Planning and Development Department of BCBSM. Mrs. Simpson, under Dr. Hayes' direction, is responsible for the development and operation of the program. This includes

the operation of the Referral Center and obtaining the support and assistance of the internal and external resources necessary to conduct the program. Included in these responsibilities are the coordination and monitoring of data collection and reporting, educational/promotional activities, claims review and claims processing, and financial reporting.

3. Alejandro P. Caragay, M.P.H., is the Referral Center Administrator and reports to Mrs. Simpson. He has responsibility for the work assignments and work quality of the Referral Center and supports Mrs. Simpson in the technical/developmental work of the program. Mr. Caragay also will provide research liaison with and assistance to the independent evaluator selected by HCFA.

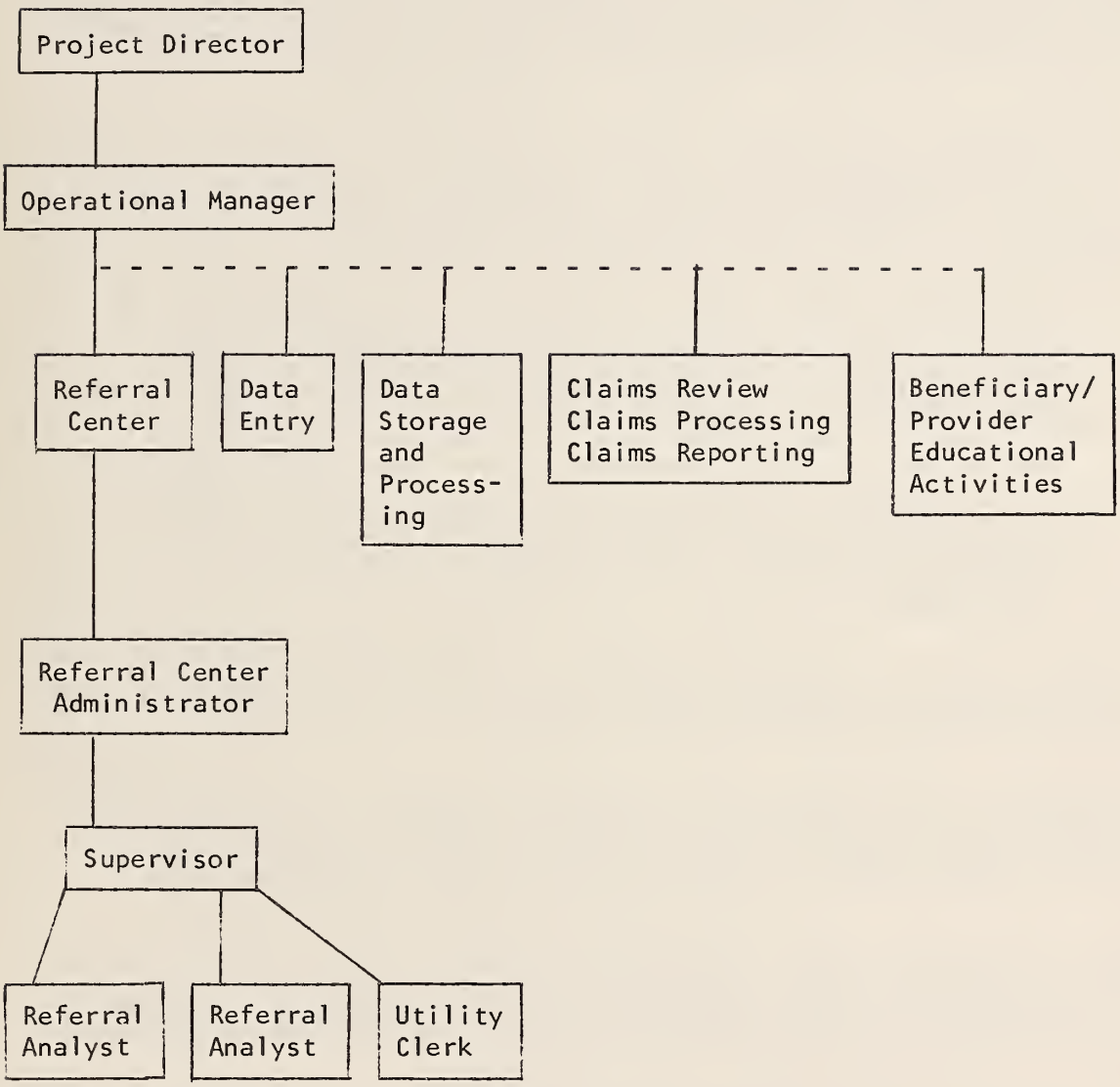
Mrs. Simpson and Mr. Caragay will ensure that the proper data under the proper conditions for valid assessment will be collected. They also perform these responsibilities for the Auto second opinion program (PROCES) and will devote a portion of their time to the Medicare Surgical Second Opinion Program. Refer to Diagram 3 for the MSSOP Organizational Chart.

E. Special Additional Support Personnel

For the MSSOP, additional personnel support will be provided by BCBSM staff concerned with claims, data processing, public relations, community relations, provider audit, accounting, and cost and budget. In addition, at no cost to the program, the BCBSM nurse in charge of benefit education for retirees, and BCBSM provider representatives who contact physicians and other providers in the community will assist in the consumer/provider education aspects of the program.

DIAGRAM 3:

MSSOP Organizational Chart



VI. ADMINISTRATIVE PROCEDURES

A. Scheduling a Second/Third Consultation Through the Referral Center

A beneficiary requesting a second/third opinion consultation relating to surgery will contact the Referral Center at (313) 225-0112 after he/she has seen a physician and discussed the possibility of elective surgery. Under the MSSOP, the beneficiary must have been seen by his/her own physician, the First Opinion Physician or F.O.P., before initiating a request for consultation through the Referral Center.

When it is determined that a telephone call from a beneficiary is a request for a second/third opinion consultation, the Referral Analyst will read the Intake Form Disclosure Statement (Appendix 20) to the beneficiary. The Disclosure Statement is as follows:

> "The authority for collecting the above information is contained in section 402(a) of the 1967 amendments to the Social Security Act as amended by section 222(b) of the 1972 amendments to the Social Security Act, P.L. 92-603. Disclosure of such information is voluntary. The information collected on this form will be used to conduct referrals and to evaluate the impact of the program. If individuals do not provide the information, they may not be able to obtain a consultation with waiver of copayment and deductible requirements."

If the caller asks for an explanation of the Disclosure Statement, this will be given by the Referral Analyst. Also, a copy of the Intake Form is mailed to the beneficiary upon request.

During this initial phone call, the beneficiary's eligibility for the program will be determined by the Referral Analyst, in accordance with procedures discussed in Item B, pages 60 to 63. Information obtained from the beneficiary is recorded on the Intake Form (Appendix 22).

Also, during this initial phone interview, the Referral Analyst will obtain the beneficiary's permission to contact his/her F.O.P. to secure the necessary medical information and results of any tests performed. However, should the beneficiary not wish to give permission to contact the F.O.P., his/her wishes will be respected.

> NOTE: It has been the experience of the Auto second opinion program that approximately 29% of patients requested that their physicians not be informed of the second opinion consultation.

If the beneficiary is eligible, he/she will be provided with up to five names of board certified surgeons whose specialties are appropriate to the beneficiary's condition and who are located conveniently for the beneficiary. The names of consultants provided to the beneficiary by

the Referral Analyst will be selected on, a rotating basis, from the list of participating consultants, and will be of the same medical discipline as the beneficiary's F.O.P.

The beneficiary will then choose a consultant from the names provided. Next, the Referral Analyst will determine if the beneficiary anticipates transporation difficulties in reaching the consultant's office, in which case the Analyst will assist in arranging transportation through one of the volunteer groups in the area.

When the consultant has been selected by the beneficiary, the Referral Analyst will contact the consultant's office and arrange an appointment date and time convenient for both beneficiary and consultant. The Referral Analyst will then phone the beneficiary to confirm appointment details, and to remind the beneficiary that all costs for the consultation and related services will be paid by the program. The beneficiary will be instructed to inform the Referral Center if he/she is billed for the consultation or any related ancillary services. Further, the beneficiary will be requested to inform his/her F.O.P. that medical information, including tests results, may be released to the Referral Center and/or the consultant.

Should the beneficiary not wish the physician to be contacted, or should the F.O.P. not wish to cooperate, the Referral Analyst will secure as much pertinent information as possible from the beneficiary so that it can be forwarded to the consultant with a notation to indicate that the information contained was provided by the beneficiary.

Once the appointment has been scheduled and confirmed by phone with the beneficiary, the Referral Analyst will prepare the consultant's package containing:

- Cover letter (Appendix 23) listing the contents of the consultant's package and the action to be taken on each form.
- Blank Consultant's Report (Appendix 24).
- Partially Completed Special Form 1490, Request for Medicare Payment (Appendix 25) to be used for submitting the consultant's claim.
- Additional Partially Completed Special Form 1490 (Request for Medicare Payment) to be used for submitting ancillary service claims.
- Instructions for Submitting Ancillary Services Claims (Appendix 26) for services performed other than at the consultant's office.

- o Completed First Opinion Physician Report Form (Appendix 27).
- o Reply envelope.

A detailed description of the Intake Form, the F.O.P. Report Form, the Consultant's Report Form and the Special Form 1490 is found in Item E.1-5, pages 65-77.

Finally, the Referral Analyst will complete and mail the Confirmation of Appointment card (Appendix 28) to the beneficiary in advance of the consultation date. This is intended to minimize the number of cancelled and rescheduled appointments.

Following the consultation, the program consultant will discuss the findings and recommendations with the beneficiary. The consultant will then complete the Consultant's Report and the claim form, and mail them to the Referral Center. The Referral Center will forward a copy of the Consultant's Report to the F.O.P., with the beneficiary's permission. Originals or copies of all completed forms will be placed in each beneficiary's folder and stored in locked file cabinets at the Referral Center.

B. Eligibility Determination Procedures for Beneficiaries Seeking Second Opinions

In order to validate eligibility of a Medicare beneficiary, the Referral Center will use the GRAMPS CRT Manual and the GRAMPS CRT.

GRAMPS is defined as the Government Records and Medicare Part B Payment System. It provides BCBSM staff with the capability to obtain Medicare eligibility and Part B payment information via CRTs. The capability of altering eligibility records or adjusting payment information via CRT is also provided, however, this function is restricted to selected responsible areas.

1. Establishing a Valid Medicare Part B Contract

The Referral Analyst will verify the beneficiary's eligibility by keying into GRAMPS to locate the file of the beneficiary requesting a second opinion.

a. Medicare HIC Number Known

The Referral Analyst will key in T/C (Transaction Code) 43 plus the HIC number. The T/C 43 will bring the beneficiary's History File into view on the GRAMPS terminal. The History File displays the beneficiary's current Medicare Part B coverage. The Referral Analyst will then verify:

- o HIC number - If the HIC number indicates that the beneficiary is a railroad retiree, the Referral Analyst will inform the beneficiary that railroad retirees are not eligible for the MSSOP. Refer to Appendix 29 for the list of railroad retiree HIC numbers.

  If the HIC number given is on the list of valid Medicare HIC numbers (Appendix 30), the Referral Analyst will proceed to the next bullet.

- o Spelling of the beneficiary's name.

- o Address - If not residing in the experimental area, inform beneficiary of ineligibility.

- o Sex Code.

- o Enrollment Date - GRAMPS must show an enrollment date on or before the date of the request for a second/third opinion.

- o Termination - If GRAMPS shows a termination date on or before the date of the request for second/third opinion, or a future termination date which will not give sufficient time to have the second/third opinion, the beneficiary will be informed of his/her ineligibility. If 99-99 is indicated, there is no termination date.

- o If GRAMPS displays such a number, the beneficiary's Medicare enrollment is under a different HIC number. There is the possibility that BCBSM may not be the Part B Carrier in which case, he/she would not be eligible for the MSSOP. The Referral Analyst will be required to re-key T/C 43 using the cross-referenced number. If no further cross-referenced number appears on GRAMPS and another Part B carrier is not indicated on the display, the Referral Analyst may proceed with the verification checks. Should another Part B carrier be indicated on the second display, it indicates that BCBSM is not the Medicare carrier, thus the beneficiary is ineligible under the MSSOP and will be so informed.

b. Medicare Number Unknown or Incorrect:

The Referral Analyst will:

- o Key into GRAMPS locator file by using transaction code 41 and the beneficiary's full name and sex code. The

display returned will be all the names which match the entry and will be used to locate the HIC number when only the name is known.

- o Identify the correct beneficiary by address, number and sex. The Eligibility Review Department will then be able to enter the information on the GRAMPS History display. A claim cannot be sent for payment before a file has been created.

If the beneficiary was not identified on the GRAMPS locator display, the Referral Analyst will:

- o Contact the SSA District Office and request a Z query of Baltimore's records to establish the beneficiary's eligibility. The response will be obtained by phone but the District office will follow up with a hard copy proof of eligibility.

- o Telephone the beneficiary to inform of his/her Medicare contract eligibility status. If the beneficiary has a valid Medicare contract, proceed to determine his/her program eligibility, Item B.2, page 62. If the patient does not have a valid Medicare contract, indicate his/her ineligibility and the reason.

- o Send a memo to the Eligibility Review Department stating the beneficiary's full name, HIC number and sex and request that a file be created when the hard copy proof of eligibility is received from the SSA District Office.

2. Establish MSSOP Eligibility

The Referral Analyst will obtain the date of the beneficiary's visit to the doctor at which time surgery was discussed, the site of the possible surgery and the type of surgery discussed. The Referral Analyst will arrange the second opinion consultation appointment unless one of the following program exclusions apply:

- o If the beneficiary was examined by the F.O.P. more than 120 days before the consultation request, the beneficiary may not be eligible and will be so informed.[27]

---

[27] When deemed medically appropriate, exceptions to this limitation may be made at the discretion of the Referral Center Supervisor in consultation with the Referral Center Administration.

- o If the site of surgery is the physician's office, the beneficiary is not eligible and will be so informed.

- o If the surgical procedure discussed is not a covered procedure under the Medicare Program, the beneficiary is not eligible and will be so informed.

C. Eligibility Determination for a Beneficiary Who Had a Patient or Doctor-Arranged Second Consultation Appointment with a Program Consultant

If a beneficiary calls and has had a second consultation which was either self-arranged or arranged by his/her F.O.P. and wants that consultation covered under the MSSOP, the Referral Analyst will obtain the beneficiary's name, HIC number, date of the appointment, and the name of the physician who provided the second opinion. The Referral Analyst will then use the procedures in the order discussed as follows:

1. Determination of Appointment Date

Determine if the appointment occurred during the operational dates of the program, 8/1/78 to 7/31/81. If the appointment did not occur between the MSSOP operational dates, the beneficiary will be informed of his/her ineligibility and the reason.

2. Determination of Status of Consultant for Self-Arranged Appointment

The Referral Analyst will check against the list of participating consultants to determine whether the physician who provided the self-arranged appointment is an MSSOP participating consultant. If the physician is not listed with the MSSOP participating consultants, the beneficiary is ineligible and will be given the reason.

3. Determination of Medicare Contract Validity

The Referral Analyst will establish the beneficiary's contract validity, as outlined in Item B.1. pages 60 to 62. If the beneficiary does not have a valid Medicare contract, he/she is ineligible for the MSSOP and the beneficiary will be given the reason for the ineligibility.

4. Determination of Claims Status

The Referral Analyst will determine from GRAMPS if claims have been submitted for the consultation the beneficiary wishes the MSSOP to cover. If claims have been submitted, advise the beneficiary that the second opinion cannot be covered by the MSSOP, for the claims have been processed and cannot be adjusted after submission.

5. Determination of Beneficiary's Program Eligibility

The Referral Analyst will determine the beneficiary's program eligibility as described in Item B.2. pages 62 to 63. If the beneficiary does not meet the program eligibility criteria, he/she is ineligible for the MSSOP and will be given the reason for his/her ineligibility.

6. Contacting Consultant Who Provided Self-Arranged Consultation

The Referral Analyst will advise the beneficiary of the need to contact the physician who provided the self-arranged consultation. Further, the Referral Analyst will inform the beneficiary that he/she will be telephoned by the Referral Center once contact has been made with his/her consultant.

The Referral Analyst will contact the beneficiary's consultant, confirm the consultation, and determine if claims for consultation and tests have been submitted. If claims have not been submitted, the Referral Analyst will request that they be held up until the Consultant's Report can be sent and completed.

7. Re-contacting Beneficiary

The Referral Analyst will call the beneficiary to inform him/her of the results of the contact with the beneficiary's consultant. If claims have already been submitted, the beneficiary is not eligible to have the second opinion consultation covered by the MSSOP, and the Referral Analyst will inform him/her of that ineligibility and the reason for it. If claims have not been mailed, the Referral Analyst will advise the beneficiary of his/her eligibility under the MSSOP.

8. Obtaining Further Data from Beneficiary

The Referral Analyst will obtain data from the beneficiary to complete the Intake Form.

9. Preparation of Consultant's Package

Assemble the appropriate MSSOP forms and forward them to the beneficiary's consultant for completion. Refer to Item A, page 59, paragraph 4 for the contents of the Consultant's Package and the instructions included.

D. Obtaining a Third Opinion Through the Referral Center

Under the MSSOP, a beneficiary can request a third opinion regardless of the second opinion consultant's recommendation. A beneficiary who wishes to obtain a third opinion calls the Referral Center at (313) 225-0112.

The Referral Analyst will:

- o Determine if the beneficiary obtained a second opinion through the Referral Center.

- o Determine the beneficiary's contract validity, especially the enrollment and termination dates of the contract. If the contract is valid, proceed to schedule a third opinion for the beneficiary in the same manner as arranging a second opinion.

- o Use a separate Intake Form to record the information for the third opinion.

- o Prepare the Consultant's Package and mail the package to the third opinion consultant.

E. Data Collection for the MSSOP

Four operational forms will be used for the Medicare Surgical Second Opinion Program. They are the Referral Center Intake Form, Consultant's Report Form, First Opinion Physician's Report Form, and the Request for Medicare Payment, Special Claim Form 1490 (or 1483 in some instances). Data pertinent to a second/third opinion consultation will be recorded on these operational forms. Beneficiaries who receive a second/third opinion consultation will have all four of these forms completed. The originals of the Referral Center Intake Form, Consultant's Report and F.O.P. Report plus a copy of the Request for Medicare Payment Claim Form will be retained in the beneficiary's folder which is stored in a locked cabinet at the Referral Center.

For ease of identification and handling, the various forms are color coded. Also, BCBSM has assigned numbers to specific data elements of each operational form, except the claim form. These numbered data elements are the ones likely to be stored on magnetic tape; however, the final decision on which elements to store will be made by the evaluator chosen by HCFA. Finally, each operational form, except the claim form, contains the appropriate Disclosure Statement in accordance with the Privacy Act.

1. Referral Center Intake Form, HCFA-36T

To accomplish the referral of a beneficiary to a program consultant, the Referral Analyst will use the Referral Intake Form (Appendix 22) to record pertinent information about the beneficiary, his/her condition, and the F.O.P. who discussed the possibility of elective surgery. In addition, HCFA-36T will provide a record of the details of the consultation appointment, telephone calls made, and distribution of the First Opinion Physician's Report, the Consultant's Report and the Request for Medicare Payment Form.

Information to be entered on HCFA-36T are as follows:

- o Beneficiary's contact with Referral Center -- Indicates the date, time and total minutes of the telephone call from the beneficiary to the Referral Center requesting a second/ third opinion. Indicate the date in numeric terms, e.g. Ø8-Ø1-78 (month, day and year).

- o Analyst -- Initialled by the Referral Analyst handling the beneficiary's request.

- o HIB Number -- Refers to the beneficiary's unique Medicare number as shown on his/her Medicare Hospital and Medical Insurance card. This number is also referred to as the HIC Number.

- o Opinion -- Indicates the type of consultation requested, i.e. whether second opinion or third opinion.

- o MSSOP Number -- Pertains to the unique number assigned by the Referral Center to the beneficiary for this program.

- o Beneficiary's Name -- Record full name of the beneficiary.

- o Beneficiary's Address -- Record beneficiary's current address, including County, State, and Zip Code. Indicate the numeric code for the county, e.g. Wayne - 83.

- o Diagnosis or Nature of Complaint -- Record the diagnosis or nature of complaint, as given by the beneficiary.

- o Dx Code -- Refers to the HICDA-2 Diagnosis Code for the diagnosis or nature of complaint.

- o Surgical Procedure Discussed (Description) -- Record the name or description of the surgical procedure which the beneficiary discussed with his/her F.O.P.

- o Proc. Code -- Refers to the Medicare surgical procedure code for the surgery discussed based on the BCBSM Physician's Manual, Section 3.

- o Was Surgery Recommended by Physician? -- Place a check mark in the appropriate box to indicate whether or not the surgery was recommended.

- o Is the First Opinion Physician a Surgical Specialist? -- Indicate the response by a check mark in the appropriate box, based on information given by the beneficiary, or from BCBSM internal sources, i.e. Professional directories or BCBSM Provider files.

- Date on Which Elective Surgery Was Discussed with F.O.P. -- Record this date, if known by the beneficiary. If exact date is unknown, obtain an approximate date of his/her last visit during which the surgery was discussed. This date will be used to determine the 120 days of eligibility criteria. Record date in numeric terms, e.g. 12-30-79 (Month, Day and Year).

- If F.O.P. Recommended Surgery, Has It Been Scheduled? -- Indicate by a check mark in the appropriate box whether or not the surgery date has been scheduled.

- Site of Surgery -- Indicate by a check mark in the appropriate box, the possible location at which surgery will be performed, i.e. Hospital Inpatient, Hospital Outpatient, Doctor's office or Other (free standing ambulatory surgical facility or surgicenter).

- Date of Surgery -- If surgery has been scheduled, indicate the date in numeric terms, e.g. 01-05-78 (Month, Day and Year).

- Name and Address of Site of Surgery -- Enter the name of the facility and the address at which surgery will be performed.

- Is Beneficiary Eligible for Consultation? -- Indicate by a check mark in the appropriate box, whether the beneficiary is eligible for a second opinion, based on the results of the eligibility determination.

- If Not Eligible, Check Reason -- Indicate by a check mark in the appropriate box, the reason for ineligibility.

For Eligible Beneficiaries Only:

- Date of Birth -- Record in numeric terms the beneficiary's date of birth, e.g. 11-05-39 (Month, Day and Year).

- Is Beneficiary Retired? -- Indicate by a check mark in the appropriate box whether the beneficiary is retired.

- Occupation (Specify) -- Record occupation only if the beneficiary is currently employed.

- Occupation Code -- Record occupation code based on codes developed by the Referral Center's coding of occupations.

- Sex -- Place a check mark in the appropriate box to indicate the beneficiary's sex.

- Marital Status -- Place a check mark in the appropriate box to indicate the beneficiary's current marital status.

- Name of First Opinion Physician -- Record the full name of the beneficiary's F.O.P., as given by the beneficiary. Be sure to record correct spelling.

- Type of Doctor (F.O.P.) -- Indicate by a check mark in the appropriate box the particular medical discipline of the beneficiary's F.O.P.

- Office Address -- Record F.O.P.'s complete office address.

- Telephone Number -- Indicate F.O.P.'s office telephone number.

- Does Beneficiary Wish F.O.P. to be informed of Consultation Request? -- Indicate the beneficiary's response to this question by a check mark in the appropriate box. If "NO", record the reason given by the beneficiary.

- Does Beneficiary Wish F.O.P. to be Informed of Consultation Outcome? -- Indicate the beneficiary's response to this question by a check mark in the appropriate box. If "NO", record the reason given by the beneficiary.

- How Did the Beneficiary Hear About the Program? -- Indicate the beneficiary's response by a check mark in the appropriate box or boxes.

- Does Beneficiary Have Other Health Insurance? -- Record beneficiary's response by a check mark in the appropriate box. If the response is "YES", place a check mark to indicate the type of insurance.

- Convenient Days and Time to Schedule Appointments -- Record beneficiary's suggestion for convenient days and times on which to schedule appointment.

- Geographic Area Preferred (Describe) -- Indicate the geographic area from which the beneficiary wishes to choose a consultant, e.g. Downtown Detroit, Downriver, North Woodward area, etc.

- Beneficiary's Telephone Number -- Indicate the telephone number at which the Referral Center can reach the beneficiary.

- Hours to Be Called -- Record "best time" to reach the beneficiary at the telephone number given.

- Name of Consultant Selected -- Record the full name of the consultant who will examine the beneficiary.

- Appointment Scheduled At: -- Indicate the complete address where the consultant will examine the beneficiary.

- Provider Code -- Indicate the unique BCBSM-Medicare Provider Code of the consultant. If a code is not available, generate a unique code for the consultant which will be used only for the MSSOP.

- Specialty -- Indicate the specialty of the consultant.

- Appointment Date -- In numeric terms, e.g. 10-15-79 (Month, Day and Year), indicate the date the beneficiary will have his/her second/third opinion consultation with the consultant.

- Appointment Time -- Indicate the time of the appointment with the consultant.

- Receptionist -- Indicate the name of the receptionist at the consultant's office who scheduled the appointment.

- Date Referral Center Telephoned Consultant to Arrange Appointment -- Indicate the date in numeric terms, e.g. 02-28-79 (Month, Day and Year).

- Total Amount Paid for Ancillaries -- Record the total amount paid for all tests performed in connection with the second/third opinion consultation.

2. First Opinion Physician's Report, HCFA-37T

The First Opinion Physician's Report (Appendix 27) will serve two purposes:

- The first purpose is to provide information which will aid the second opinion consultant in evaluating the patient's condition and rendering a second opinion.

- The second purpose is to provide information to the evaluator selected by HCFA for the demonstration program. The information will be used to assess the relationship of F.O.P. characteristics and perceptions of the beneficiary's condition to conformation or nonconformation of the surgery by the consultant and the beneficiary's decision to have or to defer the surgery.

Form HCFA-37T will be a three-part, snap-out form and will be color coded. The original of the completed form will be kept with the beneficiary's file at the Referral Center and one copy will be forwarded to the second opinion consultant along with the Consultant's Package. The third copy of the completed Form HCFA-37T will be for the F.O.P. unless the F.O.P. did not complete the form. If the beneficiary does not wish his/her F.O.P. to know of the consultation, and the beneficiary helped the Referral Analyst to complete Form HCFA-37T, the third copy will be kept in the beneficiary's file at the Referral Center.

Several means will be used to complete Form HCFA-37T:

- o If the beneficiary does not object to the Referral Center contacting the F.O.P.:
  - a Referral Analyst will attempt to obtain the necessary information by telephoning the F.O.P. directly. This will be done within one working day of the beneficiary's request for consultation.
  - if the initial telephone contact with the F.O.P. is unsuccessful due to the office staff not wishing to release information over the telephone or to the unavailability of the F.O.P. during the initial call from the Referral Analyst, the Form HCFA-37T will be mailed to the F.O.P. This will be done provided the scheduled appointment is at least three weeks away. If the completed form is not received within ten working days of the mailing date, the Referral Analyst will contact the F.O.P. to determine the status of the form. If the HCFA-37T is not completed, the Referral Analyst will attempt to complete the form over the telephone.
  - if the initial telephone contact with the F.O.P. is unsuccessful and the scheduled appointment is less than three weeks away, the Referral Analyst will phone the beneficiary asking the beneficiary to request that his/her F.O.P. provide the necessary medical information to the Referral Center. The Referral Analyst will then telephone the F.O.P. and try to secure the necessary information.
  - if the completed HCFA-37T is not received from the F.O.P. five working days prior to the date of the scheduled appointment or if the F.O.P. refuses to complete the HCFA-37T, the Referral Analyst will telephone the beneficiary and obtain as much of the needed information as possible directly from him/her.

- o If the beneficiary objects to the Referral Center contacting the F.O.P., the information needed will be obtained by a Referral Analyst during the initial telephone contact with the beneficiary. This approach is taken only after the Referral Analyst has been unsuccessful in pointing out the benefits of obtaining F.O.P. information.

The above procedures will ensure that each beneficiary will have a completed HCFA-37T which will be forwarded to the consultant prior to the scheduled appointment date. Information contained in the HCFA-37T will be in addition to any provided directly to the consultant by the F.O.P. and/or hand-carried to the consultant by the beneficiary.

The data elements to be recorded by the Referral Center on Form HCFA-37T are:

- o H.I.B. Number -- Indicates the beneficiary's unique number as shown on his/her Medicare Hospital and Medical Insurance card. Also known as H.I.C. number.

- o MSSOP Number -- Refers to the unique number assigned to the beneficiary by the Referral Center for the Medicare Surgical Second Opinion Program.

- o Beneficiary's Name -- Refers to the beneficiary's complete name as shown on his/her Medicare Hospital and Medical Insurance card.

- o Beneficiary's Address -- Refers to the complete address including State and Zip Code. Code for the County of Residence should also be shown, e.g. Wayne County - 83.

The following data elements will be completed by the F.O.P. or by the Referral Center with the beneficiary's assistance (if the information cannot be obtained from the F.O.P.):

- o Diagnosis -- Refers to the beneficiary's diagnosis as determined by the F.O.P. or as given to the Referral Analyst by the beneficiary.

- o Dx Code -- Refers to the HICDA-2 code for the diagnosis identified by the F.O.P. or provided by the beneficiary to the Referral Analyst. It is completed or verified by the Referral Analyst.

- o Was Surgery Recommended -- Indicates whether or not the F.O.P. recommends surgery for the condition for which the beneficiary seeks the second/third opinion consultation.

- Type of Surgery Recommended -- Refers to the name of the surgical procedure contemplated for the beneficiary (if surgery is recommended).

- Proc. Code -- Refers to the surgical procedure code for the surgery recommended by the F.O.P. It is based on the BCBSM Physician's Manual, Section 3, and is completed or verified by the Referral Analyst.

- Type of Surgery Discussed -- Refers to the name of the surgical procedure discussed with the F.O.P. (if surgery not recommended) for which the beneficiary seeks a second opinion.

- Proc. Code -- Designates the surgical procedure code for the surgery discussed but not recommended by the F.O.P. It is based on the BCBSM Physician's Manual, Section 3, and is completed or verified by the Referral Analyst.

- Recommended Site of Surgery -- Indicates the location at which surgery will be performed should the beneficiary decide to undergo surgery for the condition for which he/she is seeking a second opinion.

- Pertinent History, Symptoms and Findings -- Refers to the brief history on the beneficiary and includes pertinent symptoms and findings relevant to the condition for which he/she is seeking a second opinion.

- List of . . . Diagnostic Tests Ordered -- Refers to all tests performed relevant to the condition for which the beneficiary is seeking a second opinion. The names of the tests or procedures performed, the results and the Procedure Codes based on the BCBSM Physician's Manual, Section 3 are recorded. If more than six tests are ordered, the additional tests will be listed on another sheet and a check mark placed in #17. The Procedure Code will be completed or verified by the Referral Analyst.

- Name of First Opinion Physician -- Indicates the full name of the beneficiary's First Opinion Physician, i.e. the attending physician who examined the beneficiary for the condition for which consultation is sought.

- Office Address -- Refers to the office address of the F.O.P. where the beneficiary had his/her examination.

- Telephone Number -- Indicates the telephone number of the F.O.P.'s office where the beneficiary was examined.

- o Type of Practice -- Refers to the F.O.P.'s type of practice, whether solo or group. For this program a group practice means any organized group of three or more physicians, full time or part time, formally organized to provide medical services, with income for medical practice distributed according to a prearranged plan.

- o Forms Completed By -- Refers to the means used to complete Form HCFA-37T:

    - Doctor's office, mailed = The HCFA-37T was mailed to the F.O.P.'s office and completed there.

    - Doctor's office, telephoned = The HCFA-37T was completed over the telephone by the Referral Analyst with assistance from the F.O.P. or his/her designee at the office.

    - Referral Center, with beneficiary's input = The HCFA-37T was completed over the telephone by the Referral Analyst with assistance from the beneficiary. This box is only checked if the beneficiary does not wish the F.O.P. to be contacted or if the F.O.P. refuses to cooperate.

- o Date -- Indicates, in numeric terms, the date the HCFA-37T was completed, e.g. Ø8-13-78 (Month, Day and Year).

3. Consultant's Report, HCFA-38T

The Consultant's Report (Appendix 24) is the mechanism used by the second/third opinion surgeon to report his/her findings regarding a beneficiary's need to undergo elective surgery. In addition, it will be used when reviewing the Utilization File on GRAMPS to determine if claims for the consultation and any related diagnostic tests listed on the Consultant's Report have been submitted to a BCBSM area other than the Referral Center. Also, Form HCFA-38T will indicate the location at which the tests ordered by the consultant were performed. This will assist the Referral Center to determine whether the claim for the ancillary tests was submitted to the Part A intermediary or the Part B carrier.

The HCFA-38T will be a three-part, snap-out form and will be color coded. A blank HCFA-38T will be forwarded to the second/third opinion consultant, along with the other contents of the Consultant's Package prior to the scheduled appointment date. Upon completion of this form, the consultant will retain one copy and mail the others to the Referral Center, along with his/her Request for Medicare Payment Special Claim Form 1490. The original of the completed HCFA-38T will be kept with the beneficiary's file at the Referral

Center while the F.O.P. copy will be forwarded by the Referral Center to the beneficiary's F.O.P. However, if the beneficiary does not wish the F.O.P. to be informed of the consultation outcome, the F.O.P. copy will be retained with the original in the beneficiary's file at the Referral Center.

The data elements to be completed on HCFA-38T are:

- o H.I.B. Number -- Indicates the beneficiary's unique number as shown on his/her Medicare Hospital and Medical Insurance card. Also known as H.I.C. number.

- o Opinion -- Refers to the type of opinion being provided, i.e. the beneficiary's visit to the consultant is for either a second opinion consultation or for a third opinion consultation.

- o MSSOP No. -- Designates the unique number assigned to the beneficiary by the Referral Center for the Medicare Surgical Second Opinion Program.

- o Beneficiary's Name -- Refers to the beneficiary's complete name as shown on his/her Medicare Hospital and Medical Insurance card.

- o Beneficiary's Address -- Refers to the complete address including State and Zip Code. Code for the County of Residence should also be shown, e.g. Wayne County - 83.

- o Consultant's Diagnosis -- Indicates the beneficiary's primary diagnosis as determined by the second/third opinion consultant.

- o Dx Code -- Refers to the HICDA-2 code for the diagnosis identified by the second/third opinion consultant. It is completed or verified by the Referral Analyst.

- o Need for Surgery -- Designates the opinion or recommendation of the consultant regarding the elective surgery for which the beneficiary is seeking the second/third opinion.

- o Surgical Procedure Recommended by Consultant, If Surgery Confirmed -- Refers to the name of the surgical procedure proposed by the consultant for the beneficiary's condition.

- o Proc. Code -- Refers to the surgical procedure code for the type of surgery proposed by the consultant. It is based on the BCBSM Physician's Manual, Section 3, and completed or verified by the Referral Analyst.

- Recommended Location for Surgery -- Indicates the site where the proposed surgery will be performed.

- Is Surgical Procedure Recommended the Same As Recommendation of F.O.P.? -- Refers to whether the surgery proposed by the consultant for the beneficiary's condition is the same type as that proposed by the F.O.P.

- Surgery Not Recommended Because: -- Designates the alternative recommendation of the consultant, if he/she does not recommend surgery for the beneficiary's condition. A list of reasons is pre-printed on the HCFA-38T and one or more reasons may be checked.

- Consultant's Remarks for the Next Therapeutic Step: -- Refers to any additional comments the consultant may wish to include regarding his/her recommendations for the beneficiary's condition.

- List . . . Diagnostic Tests Ordered -- Refers to all tests performed relevant to the condition for which the beneficiary is seeking a second opinion. The names of the tests or procedures performed, the results, and the Procedure Codes based on the BCBSM Physician's Manual, Section 3, are recorded. If more than six tests are ordered, the additional tests will be listed on another sheet and a check mark placed in #19. The Procedure Codes will be completed or verified by the Referral Analyst.

- Location At Which . . . Diagnostic Tests Were Performed -- Gives the name and address of the facility where tests were performed and identifies the type of facility, i.e. Doctor's office, hospital or independent laboratory facility.

- Patient's Race -- Indicates the beneficiary's Race, as determined by the consultant through observation.

- Reason for Ordering . . . Diagnostic Tests -- Refers to the consultant's reason(s) for ordering diagnostic tests. A list of reasons is pre-printed on the HCFA-38T and one or more reasons may be checked.

- Signature of Consultant -- Signature of the doctor who rendered the second/third opinion consultation.

- Date of Appointment -- Indicates the date on which the consultant examined the beneficiary.

4. Request for Medicare Payment, HCFA-1490(2)

The HCFA-1490(2) Request for Medicare Payment (Appendix 25) is a three-part, snap-out yellow form which will be used by the consultant to submit a claim for payment of consultation services rendered under the MSSOP. In addition, HCFA-1490(2) will be used when submitting claims for diagnostic tests related to the beneficiary's second/third opinion consultation and performed at either the consultant's office or an independent laboratory or x-ray facility.

Before the 1490(2) form is sent to the consultant, the Referral Center will complete the following items: name of patient; Health Insurance Claim number; sex; patient's complete mailing address; telephone number; whether illness/injury is work-connected; name and adress of any other insurance organization or government agency which will or could pay for the medical expenses, and applicable identification or policy number; and the patient's wishes regarding release of information on the Medicare claim to any other insurance organization or government agency.

Two partially completed 1490(2) forms and a $5\frac{1}{2}$ x $8\frac{1}{2}$ inch card of instructions for submitting claims for diagnostic tests performed at sites other than the consultant's office (Appendix 26) will be mailed to the second/third opinion consultant, along with the other contents of the Consultant's Package prior to the scheduled appointment date.

On the day of the patient's second/third opinion consultation appointment, the patient will be asked at the consultant's office to place his/her signature in the space provided in Part 1, Item 6 of the 1490(2) form. Should additional 1490(2) forms be submitted, they must also be signed by the patient. If a 1490(2) is submitted to the Referral Center without the patient's signature, the Referral Center will return a copy of the form to the patient for the necessary signature before the claim can be processed.

Items 7 through 14 on the 1490(2) will be completed by the consultant and by the independent laboratory or x-ray facility. Instructions for completion of these items are printed on the reverse side of the form (Appendix 25). In addition to these instructions, the consultant will be directed to use the following procedure codes to identify the type of consultation service rendered:

- Procedure Code 0018 - Indicates a second opinion consultation.

- Procedure Code 0019 - Indicates a third opinion consultation.

Further, any diagnostic tests performed in relation to the consultation will be coded using the BCBSM Physician's Manual, Section 3.

Upon completion of the 1490(2), the consultant will mail the form to the Referral Center. On the date of receipt of the claim, the Referral Center will review it for completeness and whether it is a valid second opinion claim, retain one copy for the beneficiary's file and send the remaining two copies for claims processing. The procedure for claims review and claims processing will be discussed in more detail in Section VII. A.

5. Request for Medicare Payment, SSA-1483

It is anticipated that, in a few instances, SSA-1483 (Appendix 31) will be used to submit claims for payment of diagnostic tests performed at a hospital outpatient department. The Referral Center will not send this form as part of the Consultant's Package but will rely on the hospital to use its supply of SSA-1483s.

If any tests relating to the beneficiary's consultations are performed at a hospital outpatient department, the hospital will be requested to complete an SSA-1483 and mail it directly to the Referral Center. The $5\frac{1}{2}$ by $8\frac{1}{2}$ instruction card (Appendix 26) which is included in the Consultant's Package will indicate to the consultant and the hospital the procedure to follow when submitting claims for tests performed at a hospital outpatient department.

On the date of receipt, the Referral Center will review the 1483 for completeness and whether it is a valid second opinion claim, record the needed information in the appropriate log, retain a copy for the beneficiary's file and forward the claim for processing. Section VIII further discusses the procedure for claims review and processing.

F. Follow-up on Consultant's Report and Claim Form Not Received

As indicated, the completed Consultant's Report HCFA-38T and the completed Request for Medicare Payment HCFA-1490(2) or SSA-1483 which relate to MSSOP second/third opinions will be mailed to the Referral Center. If the Referral Center does not receive the Consultant's Report and/or the Request for Medicare Payment within a reasonable time from the date of the scheduled second/third opinion consultation, a follow-up procedure will be instituted:

1. Follow-up on Consultant's Report Not Received

If the completed Consultant's Report has not been received by the Referral Center within 10 days after the scheduled date of consultation, the Referral Center will phone the consultant's office to determine if the Consultant's Report has been completed and mailed

to the designated area of BCBSM, i.e. the Referral Center. If it has not been mailed, the consultant will be requested to complete it promptly and mail it as directed. Until the report is received, the Referral Center will re-contact the consultant at 10 day intervals and urge the completion and mailing of the Consultant's Report.

2. Follow-up on Request for Medicare Payment Form Not Received

If the Referral Center has not received the Request for Medicare payment for the consultation within 10 working days of the consultation appointment, a Referral Analyst will check the Utilization File on the GRAMPS to determine if the claims has been received and/or paid. If not, the Referral Analyst will contact the consultant's office and will determine if the Request for Medicare Payment form for professional services has been submitted for payment. If the Request for Medicare Payment for the consultant's services has not been submitted, the consultant will be requested to forward the completed claim form to the Referral Center as soon as possible. The preceding will be repeated every 10 working days until the Referral Center receives the completed form.

If diagnostic tests were performed and the site of service is known, the Referral Analyst will attempt to follow-up on the Request for Medicare Payment form not received within 10 working days from the date of the scheduled consultation.

G. Logging Procedures

Log sheets will be used to collect information which will assist in the preparation of progress reports for the Government and aid BCBSM management in the monitoring and operation of the program.

Information such as the following will be logged and summarized after the end of each month:

- Requests for general information, i.e. the caller is not requesting a second/third opinion consultation.

- Requests for second/third opinions, i.e. the beneficiary specifically requests a second/third opinion consultation under the MSSOP. The outcome of the request will be noted along with any other pertinent information.

- Inappropriate diagnostic tests/procedures, i.e. those tests/procedures which appear to be inconsistent with the beneficiary's diagnosis or which are components of inclusive tests/procedures also ordered by the consultant.

- Charges for tests/procedures which are higher than the Customary.

- Tests/procedures performed at a hospital Outpatient Department and claims submitted on an SSA 1483 (Request for Medicare Payment). The original of this log will be sent to Accounting, a copy will be sent to Provider Audit and the remaining copy will be retained by the Referral Center. This log will be used by Accounting to properly reimburse the hospitals for services rendered under the MSSOP. Also, Provider Audit will use this log in their audit of claims for services rendered under the MSSOP.

Additional logs will be developed if the need arises and will be submitted to the Project Officer for approval before the Referral Center adopts them for daily use.

H. Filing of Second/Third Consultation Cases (Beneficiary's File)

Four type of files will be used for beneficiary records:

- Pending File -- will contain folders of beneficiaries whose second/third opinion consultation appointments have not been verified by the Referral Center as having occurred.

- Active File -- will contain folders of beneficiaries whose second/third opinion consultation appointments have been verified by the Referral Center as having occurred, i.e. the beneficiary has been examined by the consultant.

- Cancellation File -- will contain folders of beneficiaries whose appointments were cancelled by either the beneficiary or the consultant, with no further appointment rescheduled under the MSSOP.

- Ineligible File -- will contain folders of beneficiaries who requested a second opinion consultation but who did not meet the eligibility criteria for the MSSOP. An Intake Form must have been partially completed for such beneficiaries.

1. General Filing Procedures

Color coded folders will be used to distinguish the MSSOP cases from the records of other BCBSM second opinion programs. A supply of folders containing blank operational forms, the Confirmation of Appointment card and reply envelopes will be prepared and will be available for use by the Referral Analyst when responding to incoming requests for second/third opinion consultants.

Each beneficiary who requests a second opinion consultation will have his/her own folder. The folder will contain all operational forms and documentation pertinent to the beneficiary's case.

The folder will be identified by the beneficiary's name, HIC number, MSSOP number and consultation date (if beneficiary is eligible for a second opinion). Folders will be filed alphabetically in a locked file cabinet containing MSSOP records.

Should it be necessary to remove a folder from the locked file cabinet, the folder must be signed out and then signed in again when it is returned to the Utility Clerk for refiling. Before the end of each working day, all folders removed from the file cabinet must be returned, signed back in and then refiled by the Utility Clerk. The Utility Clerk must be sure all file cabinets are locked at the end of each working day.

2. Filing Procedures for Pending File

When the second opinion consultation appointment has been scheduled and the appointment details have been confirmed with the beneficiary, the Referral Analyst will give the beneficiary's folder to the Utility Clerk for processing and filing.

The Utility Clerk will:

- Assign a unique MSSOP number for the beneficiary.
- Enter the pertinent information in the appropriate MSSOP log.
- Label the folder with the beneficiary's name, HIC number, MSSOP number and consultation date.
- File the beneficiary's folder in alphabetical order in the Pending File.

The beneficiary's folder will remain in the Pending File until it has been verified that the appointment has been completed as scheduled or has been cancelled.

3. Filing Procedures for Active File

The Utility Clerk will transfer the beneficiary's folder from the Pending File to the Active File once the scheduled appointment has been verified as completed. Before refiling, the Utility Clerk will record in the appropriate log for the MSSOP that the consultation has been verified as complete. The folder will be refiled in alphabetical order in the Active File.

4. Filing Procedures for Cancellation File

If the scheduled appointment is cancelled, the beneficiary's folder will be removed from the Pending File and the Utility Clerk will

enter the cancellation in the appropriate MSSOP log, draw a line through the consultation date which appears on the folder's label and refile the folder alphabetically in the Cancellation File.

5. Filing Procedure for the Ineligible File

If the Referral Analyst determines that a particular beneficiary is not eligible to receive a second opinion consultation through the MSSOP, the beneficiary's folder will be given to the Utility Clerk for processing and filing.

The Utility Clerk will:

- Remove the folder's contents, except for the partially completed Intake Form.
- Assign a unique MSSOP number for the ineligible beneficiary.
- Enter the pertinent information in the appropriate MSSOP log.
- Label the folder with the beneficiary's name, HIC number, MSSOP number and the date of his/her request for a second opinion.
- File the beneficiary's folder in alphabetical order in the Ineligible File.

6. Filing Procedures for Third Opinion Consultations

A beneficiary may request a third opinion consultation, subsequent to his/her second opinion consultation arranged through the Referral Center. When such a request is received, the Referral Analyst will retrieve the beneficiary's folder from the Active File and verify that the beneficiary already received a second opinion consultation through the MSSOP. This folder will be used also to hold records pertinent to the third opinion consultation. When the third opinion consultation appointment has been scheduled and the appointment details confirmed with the beneficiary, the Referral Analyst will give the beneficiary's folder to the Utility Clerk for processing and refiling.

The Utility Clerk will:

- Enter the pertinent information into the appropriate MSSOP log.
- Indicate on the folder's label the date of the scheduled third opinion consultation.

- o Refile the folder in alphabetical order in the Pending File.

I. Filing of Consultants' Records, Except Consultants' Reports

Two types of files will be used for Consultants' Records:

- o File on Current Consultants -- will contain folders of doctors currently serving as second opinion consultants.

- o File on Inactive Consultants -- will contain folders of doctors who were formerly consultants to the second opinion programs. These doctors no longer serve as consultants because of voluntary de-participation, retirement, death, or lack of professional liability insurance.

1. General Filing Procedures

Each doctor who has agreed to serve as a second opinion consultant will have his/her own folder. The folder will contain the signed Participating Agreement and other communications/documentation pertaining to his/her role as a program consultant.

Each folder will be identified with the consultant's name, provider code, specialty, office location (county), and effective date of participation. If the consultant becomes inactive, the effective date of termination will be shown and also the reason.

Folders will be filed alphabetically in the appropriate file, i.e. either the Current File or the Inactive File.

Folders of Tri-County area consultants who did not extend their participation beyond the Auto second opinion program will be tagged with a color coded label.

2. Filing Procedures -- File of Current Consultants

This file will be subdivided into four sections -- M.D.s, D.O.s, D.P.M.s, and Oral Surgeons D.D.S. Folders for current consultants will be filed in alphabetical order under the appropriate discipline of the consultant.

3. Filing Procedures -- File of Inactive Consultants

This file will also be subdivided into four sections -- M.D.s, D.O.s, D.P.M.s, and Oral Surgeons D.D.S. On the date it is determined that a doctor can no longer serve actively as a program consultant the Utility Clerk will:

- Remove the consultant's folder from the file of Current Consultants.

- Make the necessary changes to the list of consultants to reflect the change in status of the particular consultant.

- Retrieve the consultant's file cards from the Index Card Files and place them into the consultant's folder.

- Indicate the termination date on the label of the consultant's folder and the reason for the termination.

- Refile the consultant's folder in alphabetical order in the file of Inactive Consultants.

J. Filing of Miscellaneous MSSOP Communications

Files will be created for miscellaneous communications/documents other than those mentioned in Items H and I. The various files will be as follows:

- Communications from external sources -- filed according to the date of the communication. If warranted, this file will be subdivided into appropriate headings, e.g. requests for program materials, complaints, suggestions, etc.

- Communications from internal sources -- filed according to the date of the communication. If warranted, this file will be subdivided into appropriate headings.

- Reports -- filed according to the type of report, such as Monthly Progress Report, Quarterly Progress Report, Annual Report and Financial Report.

- Other files -- established as the need arises.

K. Index Card File of Consultants

Each Referral Analyst will have an index card file of current participating consultants. It will be kept on the Referral Analyst's desk during working hours and will be kept in a locked cabinet at the end of each working day.

From the index card file, the Referral Analyst will select the names of consultants appropriate to the beneficiary's condition, who are also located conveniently for the beneficiary.

The file will contain 4 by 6 inch index cards color coded by county and will be subdivided as follows:

- Primary heading -- by discipline of consultant, i.e. M.D., D.O., D.P.M., D.D.S.

- Secondary heading -- by county, i.e. office location of the consultant, Wayne, Oakland or Macomb county.

- Tertiary heading -- by consultant's specialty.

Each consultant's index card will contain the following information which will assist the Referral Analyst in providing the beneficiary with names of appropriate consultants:

- Consultant's Name
- Office Address, including County
- Office Telephone Number
- Office Hours
- Provider Code
- Date Agreement Received
- Hospital Affiliation
- Type of Practice
- Birth Date
- Professional School and Graduation Date
- Licensure Date
- Certification Data and Specialty
- Sub-specialty

To the extent possible, the index cards will be rotated as follows:

- The Referral Analyst will provide the beneficiary with names of consultants chosen from the front section of the particular specialty category.

- The card of any consultant chosen will then be refiled at the back section of the specialty category.

- The card rotation will continue giving all the consultants in a particular specialty category a chance to be chosen by a beneficiary.

At the end of each quarter, a complete audit of the index card file will be performed. This will verify if the consultants' names on file are still matched with the consultants' names on the master list of current consultants and also the current consultants' folders in the filing cabinet.

L. Data Conversion/Reporting

At intervals, the operational forms, i.e. the F.O.P. Report, Consultant's Report, and Intake Form, will be coded, batched according to type of form and sent for keypunching. The data conversion instructions will be prepared by Blue Cross and Blue Shield of Michigan Systems management.

The necessary data from these input documents (operational forms) will be stored on magnetic tapes and sent to the HCFA or its designee so that a common data base of beneficiary consultation information can be developed for analysis by the independent evaluator designated by the HCFA. Based on the provisions of the contract, magnetic tapes containing "raw data", i.e. without performing any computer logic editing for validity, will be sent to the HCFA or its designee no more frequently than quarterly, because of limited data on each tape.

In addition to the data captured from the F.O.P. Report, Consultant's Report and Intake Form, the claims experience of Medicare Part A and Part B from the experimental area and the control areas will be collected. The claims experience to be collected will be for the three years before the implementation of the MSSOP, as well as for the three years of the program's operation. The data collected will be submitted on magnetic tapes to the HCFA or its designee for use in the evaluation.

M. Privacy of MSSOP Records

The data collected for the MSSOP will be protected by properly implementing the principles and safeguards of the Privacy Act. Safeguards have been developed to:

- Ensure the security and confidentiality of the data and protect against any anticipated threats of hazards to their security and integrity.

- Ensure that the information collected is not used or disclosed without the individual's permission for purposes which are not the same or compatible with uses required by the demonstration program.

For these reasons, no untoward effect from the disclosure of information relating to beneficiaries and physicians is anticipated.

The authority for maintenance of the record system is provided by Section 402 (a) of the 1967 Amendments to the Social Security Act, as amended by Section 222 (b) (1) of the 1972 Amendments to the Social Security Act, P.L. 92-603. A Privacy Act Systems Notice for Medicare Second Surgical Opinion Experiments was published in the Federal Register on Thursday, March 23, 1978, Vol. 43, No. 57, pp. 12088-89.

VII. CLAIMS PROCESSING OF HCFA-1490(2), REQUEST FOR MEDICARE PAYMENT

A. Referral Center Claims Review

As indicated in Section VI. E.4, page 76, a special yellow HCFA-1490(2) will be used by the consultant and independent laboratory or x-ray facility when submitting claims for services rendered under the MSSOP. Because the HCFA-1490(2) will be uniquely color coded and controlled through the Referral Center rather than through normal channels, no Automated Input (i.e. tape to tape reporting) will be accepted from providers for Part B services related to this demonstration program.

When a consultation appointment has been arranged by the Referral Center for an eligible Medicare beneficiary, the Referral Center will send the program consultant a consultant's package which includes two partially completed HCFA-1490(2) forms.

After 10 working days have elapsed since a consultation appointment, if the Referral Center still has not received the HCFA-1490(2), the consultant's office will be contacted by the Referral Center to determine if the claim has been submitted. The consultant's office will be recontacted every 10 working days until the claim form is received.

If the consultant indicates the claim has been submitted, the Referral Center will verify daily, using the T/C 43 or GRAMPS CRT to determine if the claim was misdirected to the routine Medicare claims processing system. See Item 6, page 93, for misdirected claims handling.

1. Review for Completeness and Accuracy

When the claim is received by the Referral Center from the consultant, the Referral Analyst who arranged the consultation will check the form for completeness and accuracy, after confirming that the claim represents a consultation approved for the program as follows:

- Items 1-3, Patient Identifiers -- Check that these are the same as originally filled in by the Referral Center. The eligibility of the HIC number will be verified as outlined in Section VI. B.1, page 60.

- Item 4 -- Must be completed "Yes" or "No" to insure that payment is not made for services which would be covered under Workmen's Compensation.

- Item 6 -- Must have an acceptable beneficiary signature as identified in the BCBSM Reference Manual, Section III.

In addition, Part II of the HCFA-1490(2) will be reviewed according to procedures identified in the BCBSM Medicare Reference Manual, the Physician's Manual and 50th Percentile Screen.

- Item 7A -- Date of service must be within the period of the MSSOP. A date must be indicated for each service.

- Items 7B and 7C -- Place and type of service are coded in accordance with the instructions in the Physician's Manual. The two codes are included with the four digit code which identifies the specific procedure. The Medicare procedure code or a conversion of the written description of the service to a procedure code identified in the Physician's Manual or the 50th Percentile Screen is determined by the Referral Analyst. NABSP and Michigan Uniform Procedure Coding structures are not acceptable for Medicare.

- Item 7D -- The Referral Analyst will compare the written diagnosis or HICDA diagnostic code to the services rendered to determine if the services are medically appropriate. Services not deemed appropriate will be recorded in the appropriate log.

- Item 8 -- Must include the provider's full name, title, address, telephone number and professional identification number (P.I.N.) or provider code. The PRISM CRT is used to validate that the P.I.N. is active for the dates of service indicated.

- Items 9, 10 and 11 -- Must be completed, identifying the total charges, amount paid and the unpaid balance.

- Item 12 -- Must be checked to determine whether the provider accepts or does not accept the assignment. Since the MSSOP is primarily for assigned claims, the Referral Analyst must be sure that the correct box is checked. If the "assigned" box is not checked, payment is routinely sent to the beneficiary. If the "assigned" box is not checked, the Referral Analyst will phone the provider to determine if assignment is acceptable. If the provider refuses assignment and the beneficiary has verified the out-of-pocket expense, a special check to the beneficiary will be requested as shown in Item 4, page

  To avoid receiving claims which are not "assigned", the program requires the consultant to sign an agreement accepting the program's consultation fee. Also, an instruction card is provided to the consultant to forward to the independent laboratory or x-ray facility from which the

related ancillary tests are ordered. This card requests the laboratory or x-ray facility to accept assignment. A consultant can be removed from the list of MSSOP participating consultants if refusing to accept assignment -- on the basis of his signed agreement. However, there is no such agreement with independent laboratories or x-ray facilities because the consultants may order their tests from various facilities.

- Item 13 -- If services were rendered at a location other than the consultant's office, the name and address of the person or facility must be indicated.

- Item 14 -- Must contain the physician's signature and the date. Acceptable physician signatures are identified in the BCBSM Medicare Reference Manual, Section III.

When information, other than signatures (Items 6 and 14) is missing the Referral Analyst will review data available or contact the provider by telephone for the missing information. The missing information will then be recorded on the Medicare Development Check List form (Appendix 32) and attached to the HCFA-1490(2).

If the beneficiary's or the provider's signature is not on the claim form (Items 6 and 14), the Referral Analyst will instruct the Utility Clerk to return a copy of the claim form to the beneficiary or provider with a note explaining that a signature is required on the above. Upon its receipt, the signed copy will be attached to the original claim for processing.

2. Claims Processing -- Consultant's Claims

The consultant's claim will be reviewed to determine that the correct procedure code has been used to identify the services. These codes are:

- Procedure Code 0018 - to designate second opinion consultation.

- Procedure Code 0019 - to designate third opinion consultation.

The charge for the consultation will be reviewed to comply with the program specifications which are:

- The consultant will be paid based on charges but not to exceed $50 per consultation.

- o Consultant claims will be priced in accordance with instructions in the BCBSM Medicare Reference Manual, Section VII and VIII.

- o To assure that the claim is not computer priced by UCR screens, when charge is $50 or less, a dash will be placed beside the charge in the Leave Blank column on the HCFA-1490(2) or in the Amount To Be Paid column on the pricing attachment.

- o When the charge is more than $50, $50 will be indicated in the Leave Blank column on the HCFA-1490(2) or in the Amount To Be Paid column on the pricing attachment.

3. Claims Pricing -- Ancillary Services Related to Consultation

Instructions will be released to providers to send claims for ancillary services related to second/third opinion consultations for this program directly to the Referral Center.

The Referral Center will periodically review utilization on the Cathode Ray Tube when a claim for ancillary services reported on the Consultant's Report has not been received. This will be done in order to determine if the claim was incorrectly submitted through the regular channels rather than to the Referral Center. Should this have occurred, the following steps will be taken:

- o A claim for a special payment to be issued to the beneficiary will be prepared after verification that the beneficiary had to pay out-of-pocket for any part of the service. This special payment procedure is outlined in Item 4, page

- o The provider's claims will not be adjusted as it has already processed through the system without the appropriate codes. It is not expected that this situation will occur, but if it should occur, reversing the claim would be costly. The Referral Center records available for evaluation will record the total amount paid for the ancillaries.

For claims which have been received by the Referral Center, the Referral Center will:

- o Verify that the ancillary services reported on the claim are the same as those recorded by the consultant on the Consultant's Report.

- o Review the charges for the ancillary services against the provider Customary Screen (UCR).

- o Continue in the processing and pay as billed any claim submitted with charges equal to or less than the customary rate.

- o Question any claim submitted with charges greater than the customary rate by a phone call to the provider. If the provider refuses to reduce the charges, the Referral Center will manually price and pay the claim at the submitted charge. Such claims will be logged.

Next, the Referral Center will review the tests ordered to determine their appropriateness. The Referral Analyst will:

- o Request clarification from the consultant if a test is ordered which does not appear to be appropriate for the diagnosis reviewed. This is also done because a coding error could have occurred. If the consultant indicates that the test was actually ordered and it is not a coding error, the test will be approved for payment but a log will be maintained, by provider, identifying the situation.

- o Review the tests to determine if an inclusive test as well as an individual test which is included in the inclusive tests was ordered. The consultant will be contacted, when this occurs, for clarification and a log maintained of the instances in which this happens. The claim will be approved.

4. Special Payment Procedure to Pay the Beneficiary for Out-of-Pocket Expenses for Ancillary Services

When the beneficiary submits evidence that he/she has experienced out-of-pocket expenses associated with an eligible MSSOP service, a special payment will be generated. (The beneficiary will be informed by the Referral Analyst if the service is not eligible.) For eligible services, the Referral Analyst will:

- o Review the GRAMPS after keying in a T/C 43 to determine which service(s) resulted in the additional charge.

- o Using the information available in the beneficiary's file within the Referral Center and the utilization data on the CRT, complete an HCFA-1490(2). In place of signatures in Items 6 and 14, the Referral Analyst will indicate: "See original claim on file with control number _ _ _ _ _ _ _ _ _ _."

- o Check off the "I do not accept assignment" box in Item 12 on the HCFA-1490(2).

- o Review and verify that all portions of the HCFA-1490(2) claim form have been completed in accordance with the

procedure for checking the HCFA-1490(2) claim form as indicated in Item 1 pages 86 to 88 and the BCBSM Medicare Reference Manual.

- o Price the claim on the attachment (Appendix 33) with a force code 5 in the Adjustment column. Pricing entries should be copied from the original payment on the GRAMPS CRT, except for the amount to be paid.

- o Determine the amount to be paid per service by subtracting the amount that Medicare paid from the original charge indicated on the GRAMPS CRT. The difference will be the amount to be paid. If the total of the amounts to be paid exceeds the out-of-pocket expense, reduce the amounts to be paid to equal the out-of-pocket expenses. If the total of the amounts to be paid for eligible services is less than the out-of-pocket expense, only the amounts for eligible services will be paid. Out-of-pocket expenses in excess of eligible services should be rejected on the pricing attachment. The procedure code would be 009998, and NP 9 should be indicated in the amount to be paid column.

The special payment procedure to reimburse the beneficiary for out-of-pocket expenses for ancillary services was the more effective alternative than the issuance of a special manual check. The special payment procedure makes use of Medicare Part B controls with the computer to insure the accuracy of the payment. By using the special payment procedure MSSOP statistics will be incorporated in the same format as other MSSOP claims on the Part B History tapes for the program evaluator. This could not be accomplished if payment was made using a special manual check.

5. Coding, Batching and Release for Payment

The Referral Center will sort claims for payment as follows:

- o Prime category sort

  - Second Opinion Consultation

  - Third Opinion Consultation

  - Second Opinion Radiology including mammograms

  - Third Opinion Radiology including mammograms

  - Second Opinion Pathology including EKG, EEG, EMG, pulmonary function, Ultra Sound and Audiogram

  - Third Opinion Pathology including EKG, EEG, EMG, pulmonary function, Ultra Sound and Audiogram.

- o Sort preceding categories into the following sub-categories:

  - Assigned Flats, i.e. claims received without additional attachments and payment goes to the provider.

  - Assigned Adjustments, i.e. claims for additional payment which will be made to the provider.

  - Non-assigned Flats, i.e. claims received without additional attachments and payment goes to the beneficiary.

  - Non-assigned Adjustments, i.e. claims for additional payment which will be made to the beneficiary.

Batch Tickets (6750-4) will be completed for each sub-category of claims. Each pack of claims will be identified on the batch ticket by sub-category. The appropriate box on the batch ticket, assigned flats, non-assigned flats, or other (assigned adjustments or non-assigned adjustments) will be checked on the batch ticket. The batch ticket will be stamped with the Referral Center identification stamp.

The Referral Center will identify the control number on the claim in the appropriate ranges listed below. Claims will be continual coded by the preceding sub-categories within the prime category range of control numbers:

650000 - 65499	Second Opinion Consultation
655000 - 65999	Third Opinion Consultation
660000 - 66499	Second Opinion Radiology, including mammograms
665000 - 66999	Third Opinion Radiology, including mammograms
670000 - 67499	Second Opinion Pathology, including EKG, EEG, pulmonary function, Ultra Sound, EMG and Audiogram
675000 - 67999	Third Opinion Pathology, including EKG, EEG, pulmonary function, Ultra Sound, EMG and Audiogram

NOTE: These control numbers will not be used for any other projects or for any claims that are not related to this Second Opinion Demonstration Project. The special ranges of control numbers will allow the computer to

identify and generate the unique Type of Service codes being used by the New York Demonstration Program and they will be placed on the SSA Payment Tapes going to Baltimore. The volume of these claims will be low and should be easy to control.

The computer program has been written to limit the services allowable for the consultation and radiology ranges but to accept multiple radiology/pathology and/or consultation services submitted (i.e. billed) on one claim under the 67000 to 67999 ranges. This will insure that MSSOP claims will be paid. The Referral Center will require resubmission by the consultant who includes the consultation service with the ancillary services. However, radiology and pathology could be submitted on the same claim. Where possible, separate claims will be requested for these multiple services.

The batches of approved claims will be sent by the Referral Center to the Manual Operations area using a special Batch Ticket for MSSOP claims.

6. Misdirected Claims

A consultant's claim which was not sent to the Referral Center but misdirected to the regular Part B claims processing area will be unacceptable in the claims payment system. This is because the claim would not have the appropriate control number range for unique procedure codes of this program. It will then be referred to the Referral Center for review and processing.

However, a misdirected ancillary claim cannot be identified by the claims payment system. When the Referral Center identifies this situation from a review of the GRAMPS terminal, an adjustment will be processed to pay the beneficiary for any out-of-pocket expense, but the misdirected ancillary claim will remain as processed on the claim files, without the demonstration program's unique coding. The out-of-pocket expense could be for a beneficiary's deductible and copayment or the difference between the Part B payment and the laboratory or x-ray facility's charges for unassigned bills.

B. Manual Operations Area -- Claims Processing

Because of the batching, special control number ranges, and Referral Center review and approval of claims, the MSSOP Second Opinion claims related to this project will not process through the Adjudication portion of the normal claims processing flow. Instead, they will be forwarded to the Manual Operations Department with the batch ticket. The special control numbers will be placed on the claims by the Referral Center before submission to Manual Operation Department where they will be microfilmed.

After microfilming, the Manual Operations Department will forward the claims directly to the Direct Data Entry Control section where they will load the claims to the T-18 Data Base for control, re-verify the valid beneficiary and address and enter the claim and services into the computer for processing and eventual payment.

C. Computer Claims Processing

Approved MSSOP claims will be entered into the computer system for processing and eventual payment only after they have been reviewed and priced at the Referral Center and further processed in the Manual Operations area.

1. Editing

All normal edits will be performed with these claims, such as eligibility, reasonableness tests, HIC validations, pre-payment screens, duplicate checking, etc.

A computer edit will result in a computer write-off when the amount to be paid for a MSSOP ancillary service is in excess of $50. This will prevent incorrect payments because of keypunch and pricing errors.

Force codes will be used by the Unit II Senior Examiner to override claims processing edits except for force code 5 which is used by the Referral Analyst to generate a special payment for out-of-pocket expenses for ancillary services. The special payment procedure for beneficiary reimbursement for out-of-pocket expenses for ancillary services is outlined in Item A.4, pages 90 to 91.

2. Deductible Query

The computer system will not send a deductible query. Appropriate "Z" queries, if necessary, will be generated to verify eligibility.

3. Creating Types of Service Codes

Using the control number, the computer program will be adjusted to create the following Types of Service codes on the SSA payment records:

- o S = Second Opinion Consultation
- o T = Third Opinion Consultation
- o U = Second Opinion Radiology including mammograms
- o V = Third Opinion Radiology including mammograms

- o W = Second Opinion Pathology, including EKG, EEG, pulmonary function, Ultra Sound, EMG and Audiograms

- o X = Third Opinion Pathology, including EKG, EEG, pulmonary function, Ultra sound, EMG and Audiograms

4. Qualitative Analysis System

MSSOP claims will not be included in the Qualitative Analysis System. The system has been changed not to consider MSSOP claims for qualitative analysis at the present time.

The Carrier Standards and Development Section of the Medicare Bureau has agreed to permit the system to be bypassed for six months at which time they will reevaluate this decision.

D. Computer Edit Error Write-Offs

Any of the MSSOP claims that edit will be returned to Medicare Adjudication I, Unit II Senior Examiner. If the Senior Examiner has any questions about the claim the Referral Center will be contacted for the necessary information to correct and re-enter the claim. Otherwise, the Senior Examiner will review, correct and resubmit the claim to Direct Data Entry Control for resubmission.

E. Provider Checks

Utilizing the special ranges of control numbers, the program producing provider checks will identify MSSOP claims with the words "Second Opinion Demonstration Project" printed after the beneficiary's name.

F. Beneficiary Checks and Explanation of Medicare Benefit Forms

Utilizing the special control number ranges, "Second Opinion Demonstration Project" will print in the Remarks section of the Explanation of Medicare Benefits when a service related to MSSOP is paid.

"Second Opinion Demonstration Project" will be identified on computer checks written to the beneficiary, whenever the beneficiary is reimbursed for out-of-pocket expenses. The special control number ranges will identify the checks to be printed with this explanation.

G. Maintaining Second Opinion Demonstration Claims History

The SSA payment tapes sent to Baltimore will display the unique Type of Service codes described herein. The Payment Tape Record does not carry the unique control number.

The Part B History Tape maintained at BCBSM will identify these claims using the unique control number ranges. This record does not carry the

Type of Service codes, but the ranges of control numbers will identify the type of claim. If the program evaluator needs the Type of Service codes on the tapes provided for the evaluation, the program for the extraction of the claims for the evaluator could also include the conversion from the control number to the Type of Service code.

The Intake Form, prepared by the Referral Center for each person receiving a second or third opinion, will be posted with the amount of the Consultant's payment and the total amount paid for ancillary services related to the consultation. The Intake Form along with the Consultant's Report and the First Opinion Physician Report will be data converted (refer to Section VI. L, pages 84 to 85) and available on computer tapes for the evaluator.

H. Corrective Actions Taken for Payment Records Rejected Under the Experiment

1. When the service was reimbursable under the experiment (i.e., the type of service is coded S-X) and the payment record was rejected because "9" was not recorded in the high order position of the deductible applied field, the record will be corrected in accordance with the instructions given in Section 13071.A.1 of the Medicare Carriers Manual (MCM).

2. When the service was reimbursable under the experiment as consultation services (i.e., the type of service is coded S or T) and the payment record was rejected because the medical charges and/or the reimbursement amount exceeds $50.00, the record will be corrected in accordance with Subsection A.s.b.2) of MCM Section 13071.3.

3. When the service was reimbursable under the experiment (i.e., the type of service code is S-X) but was reimbursed at 80 percent of the reasonable charges, resulting in an underpayment:

   a. The medical charges in the payment record will be adjusted so that it equals the reimbursement amount (ensuring that a "9" is recorded in the high order position of the deductible applied field) and the record will be resubmitted in a correction batch series.

   b. A supplemental check will be issued to cover the underpayment.

   c. An entry code 2 (supplemental debit) payment record in the same amount as the supplemental check will be prepared showing "9" in the high order position of the deductible applied field, and the record will be resubmitted in a payment series batch. (See MCM Section 13099, Exhibits 22-22C, Table for Code C Rejects).

I. Flow Chart

Diagram 4, MSSOP Claims Processing of HCFA-1490(2), displays the flow of the HCFA-1490(2) from the time it arrives at the Referral Center up to the keying of the information contained in the claim form by Direct Data Entry.

DIAGRAM 4:

MSSOP Claims Processing of HCFA-1490(2)

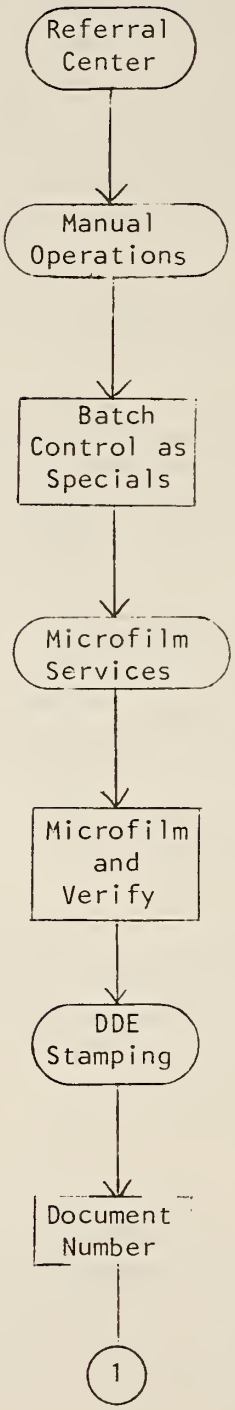


DIAGRAM 4 (Continued):

MSSOP Claims Processing of HCFA-1490(2)

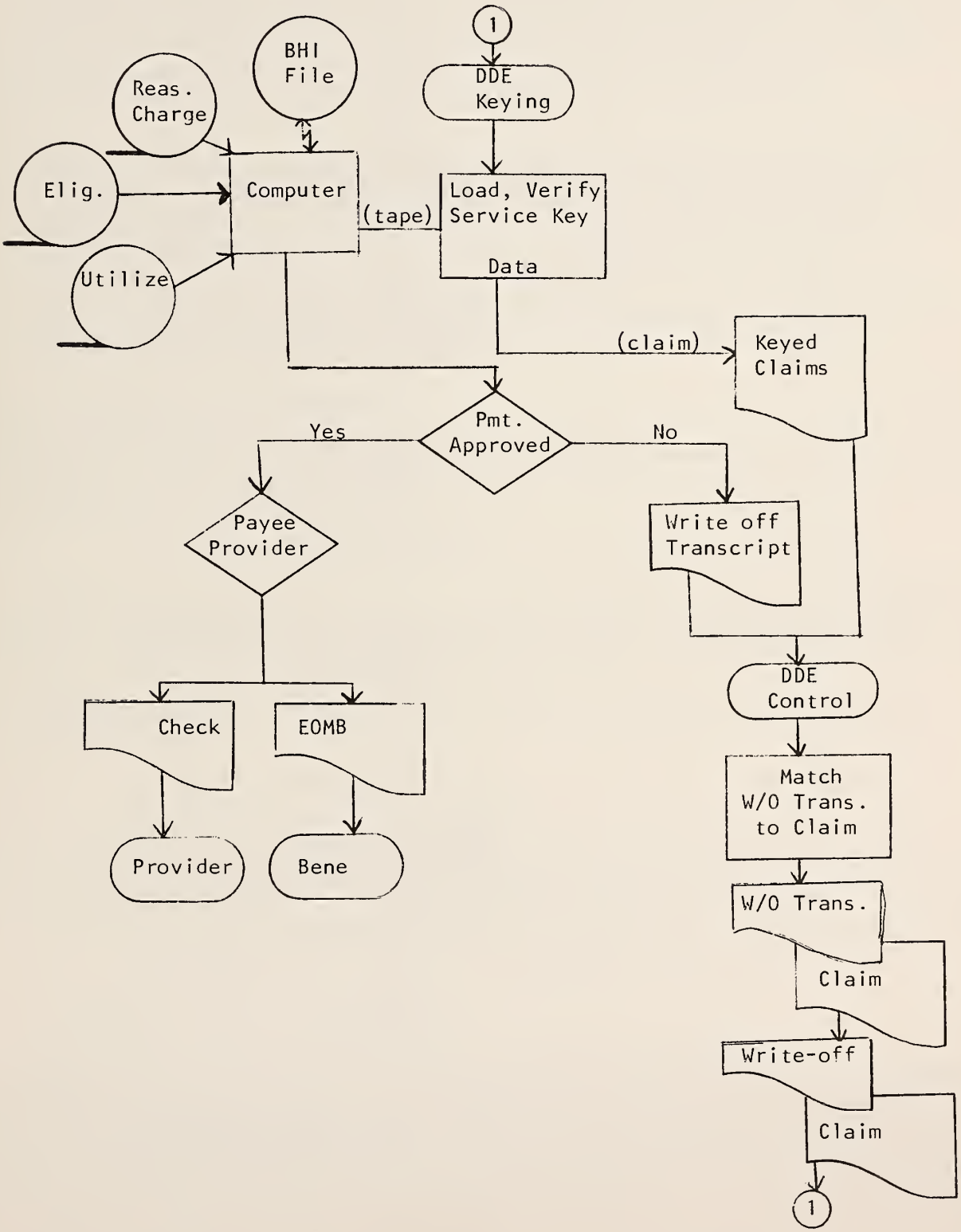
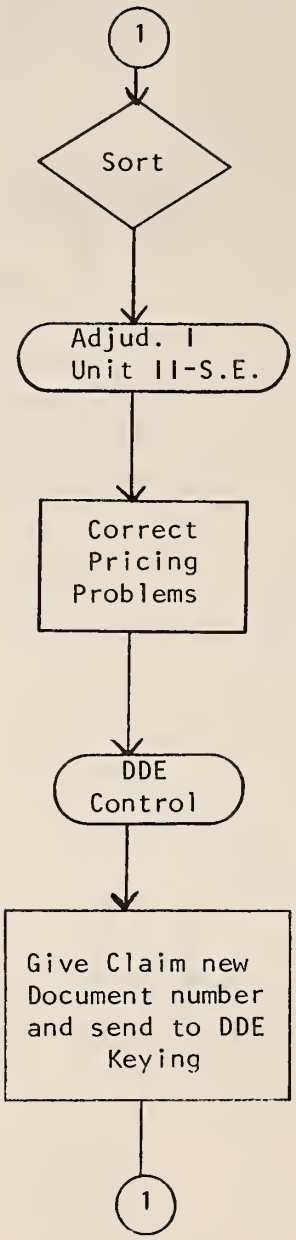


DIAGRAM 4 (Continued):

MSSOP Claims Processing of HCFA-1490(2)



VIII. PROCESSING OF SSA-1483 PART B CLAIMS BY PART A INTERMEDIARY

A. Problem

The MSSOP contract specifications for the demonstration require that the beneficiary not be liable for any deductible or copayments for services provided in connection with a second or third opinion under the program. Both Part B internal claims processing and the Baltimore system will be modified to bypass deductibles and copayments for Part B claims.

However, ancillary tests ordered by the consultant from a hospital laboratory or radiology outpatient department are reported to the Part A Intermediary on claim form SSA-1483 and processed against the deductible/copayment checks in the Baltimore Part B system. Since these demonstration claims reported on SSA-1483 are expected to be of a very low volume, computer system changes do not seem feasible. Therefore, another solution is necessary so that the beneficiary will not be subject to out-of-pocket expenses for deductibles/copayments for laboratory and radiology claims reported on SSA-1483 to the Part A Intermediary.

B. Submission of SSA-1483

So that a beneficiary will have no out-of-pocket expenses for tests ordered by the consultant from a hospital outpatient department, the hospital will be advised:

- Not to bill the beneficiary for any copayment or deductible.
- To submit all SSA-1483 claims for ancillary services covered by the MSSOP directly to the Referral Center rather than through their normal Claims Processing Systems.

The hospital will receive this information on submission of SSA-1483 claims through:

- A bulletin sent to all hospitals in Wayne, Oakland and Macomb counties.
- Personal meetings with hospitals in the Tri-County area which are most likely to perform tests for consultants.
- An instruction card which will be forwarded by the consultant to the hospital which will perform the tests ordered.

C. Referral Center Claims Review

Upon receipt of the SSA-1483 claim, the Referral Center will:

- Verify that the claim is related to an approved second/third opinion consultation.

- o Check the claim for completeness and accuracy of information entered.

- o Enter the claim information in the appropriate log.

- o Prepare documentation for the Intermediary's Accounting Department so that a check can be prepared for reimbursement of the hospital at 100% of the hospital's cost.

D. Reimbursement

The Intermediary's Accounting Department will reimburse the hospital and request reimbursement from the Medicare Part A Intermediary's Part B Trust Fund at periodic intervals -- but no more frequently than monthly. Because the volume of SSA-1483 claims for the MSSOP is expected to be extremely small, the intervals for reimbursement are expected to be quarterly or semi-annually. Reimbursement to the hospitals and the charge to the Medicare Program Trust Fund will be made at the same intervals.

Appendix 34 displays the Monthly Intermediary Financial Report, SSA-1522 which will be used by the Intermediary's Accounting Department to show the monies paid to the hospitals for services rendered under the MSSOP and to seek reimbursement from the Medicare Program Trust Fund. Along with SSA-1522, the Intermediary's Accounting Department will also use the Payment Voucher on Letter of Credit Transmittal, SSA-1521 (Appendix 35) to seek reimbursement from the Medicare Program Trust Fund.

E. Auditing

A copy of the log on which the Referral Center maintained SSA-1483 claims information will be given to the Intermediary's Provider Auditors for their use during the audit period.

F. Adjustment

If the hospital inadvertently sends the SSA-1483 to the Intermediary and charges the beneficiary, the Intermediary will prepare and process a "cancelled only" adjustment bill and will advise the hospital to:

- o Prepare and submit a corrected SSA-1483 to the Referral Center for 100% reimbursement.

- o Refund to the beneficiary or any third party payor the copayment and any deductible which may have been received from them.

G. Alternatives Considered for Processing SSA-1483 Part B Claims by Part A Intermediary

Other alternatives were considered for processing SSA-1483 Part B claims by the Part A Intermediary so that copayment and deductibles could be waived. However, these alternatives were found not feasible.

1. Issue Individual Special Check for Copayment and Deductible

The SSA-1483 Part A claim would be routed to the Referral Center which would make a copy of the bill and forward it to the Part A Claims area to be processed through the Part A system and be subject to copayment and deductibles. After payment, the Referral Center would reference the Part A beneficiary's file to determine what was paid, and develop a form to send to Accounting to issue a special check covering the copayment and deductible amount that Part A had not paid. This would require that the Referral Center reference all Part A payment files.

This alternative was not adopted because:

- The beneficiary would be credited towards meeting copayments and deductibles which were actually never met i.e., second opinion ancillaries would be credited to meeting T-18 regular program copayment and deductibles.

- It would result in the automatic generation of an EOMB which the beneficiary could use to request reimbursement for the copayment/deductible from his/her complementary carrier. If that carrier was BCBSM, the copayment/deductible would be automatically reimbursed by BCBSM. This would result in double payment of the copayment/deductible.

2. Bypassing Claims Processing Involvement

The SSA-1483 would be sent to the Referral Center which would code the claim for 100% payment, then send it to Accounting to write a special check on a manual basis. There would be no Claims Processing Department involvement.

Alternative 2 was not found viable because:

- There would be no history of the services on the Part A patient file as the claim and data would bypass the Part A system.

- The data could be manually accessible.

- o There would be an impact on Accounting to write special checks for all services.

- o The Intermediary would be paying claims from hospitals on a charge basis which are supposed to be reimbursed on a cost basis. This would require Government approval.

3. Data Transfer to SSA-1554

The SSA-1483 claim would be sent to the Referral Center which would transfer the data to an SSA-1554 and send the form to Claims for processing through the Part B system. The Part B system would bypass the copayment and deductibles.

The problems with this approach were:

- o Expenses which should have been paid by the Part A Intermediary would be paid by the Part B Carrier.

- o There were questions about the legality of transferring data from one form to another.

- o Reimbursement would be made on charges rather than the hospital's cost reimbursement basis.

4. Pre-calculation at 100%

The hospital would have to send the SSA-1483 claim form to the Referral Center. This would require the consultant who ordered the tests from the hospital to advise the hospital to send a hard copy SSA-1483 claim to the Referral Center. The Referral Center would send the claim to a specific location in the Medicare A Claims identifying it as an MSSOP claim requiring pre-calculation at 100%. The Referral Center would also insert codes in the Remarks section to identify the claim as ancillaries related to a second/third opinion.

Upon checking with Baltimore's Division of Systems, it was found that this solution would not work. This is because the Part A claim which enters the Part B system to update copayment and deductible amounts would be rejected due to lack of deductible/copayment amounts on the claim when the Part B deductible/copayments had not been met.

5. Transfer to Copayment/Deductible to HCFA-1490(2)

The hospital would send the SSA-1483 claim form to the Referral Center. It would be processed in its normal way, but the Referral Center would prepare an HCFA-1490(2) claim form for reimbursement of the deductible/copayments.

This suggestion was found to have the same problems as in Alternative 3.

6. SSA-1483 Not Reimbursed at 100%

Those demonstration project services reimbursed by Medicare on a cost basis (i.e. utilizing an SSA-1483 claim form) rather than on a reasonable charge basis would be subject to the normal Medicare deductibles and copayments and would not be subject to 100% reimbursement by Medicare.

This alternative was not accepted by HCFA since it would be contrary to the intent of the MSSOP which is to pay 100% for services rendered for second/third opinions.

7. Maintenance of Logs by Hospitals for Beneficiaries Without Supplemental Coverage

If the beneficiary had health insurance supplementing Medicare, the third party carrier would cover the deductible or copayment amounts. However, if a beneficiary for whom ancillary services are provided has no health insurance supplementing Medicare, the hospital would be advised not to bill the beneficiary for any copayment or deductible. The hospital will be required to maintain a log of copayment/deductible amounts by case, so that it can be reimbursed appropriately upon cost settlement.

This alternative was found not feasible since it would be difficult for hospitals to administer, and it is not the intent of the program to have third party payors be liable for the deductible and copayment amounts.

8. Reimbursement of Out-of-Pocket Expenses through Part B Carrier Checks

For only those beneficiaries without coverage supplementing Medicare, a check would be issued covering their out-of-pocket expenses if proof of their payment and the EOMB was received. This check would be generated from the Part B Carrier. The third party payor for those with such coverage would pay for the deductible and copayments for their members.

This was rejected because the deductibles and copayments should be an expense of the Part A Intermediary and because the program's intent is not to have third party payors cover the deductible and copayments.

IX. POLICY DECISIONS ON COVERAGE AND OPERATION OF THE PROGRAM

During the development of the demonstration program, the following policy issues pertaining to coverage and operation of the program were brought to the attention of the Project Officer for resolution:

- Patient arranged consultation -- Second opinion consultations arranged by the beneficiary, bypassing the Referral Center, will be covered provided the claim has not already been submitted to the normal Claims Processing system for payment.

- Ancillary services not currently covered under Medicare -- Ancillary tests ordered by the consultant which are not currently covered by Medicare will not be paid by the MSSOP.

- Surgical Procedures which are not current Medicare benefits -- Any surgical procedure which is a current Medicare contract exclusion will not be eligible for a second opinion under the MSSOP.

- Transportation from Skilled Nursing Facility to Consultant's office -- The MSSOP will not cover expenses for transportation of a beneficiary from a skilled nursing facility to a consultant's office. This also applies to any transportation expense incurred by a beneficiary in reaching a consultant's office.

- Payment for tests -- Tests ordered by the consultant, provided they are benefits covered by Medicare Part B, will be paid using the Prevailing or Customary charge, whichever is less.

- Out-of-pocket expense -- A beneficiary will be repaid for any deductible or copayment which he/she paid out-of-pocket.

- Tests performed on an inpatient basis -- Any tests ordered by the consultant and performed on an inpatient basis will be covered under Medicare Part A with applicable deductibles and copayments applied. However, the consultation fee will be paid under the MSSOP.

- "Medically Unnecessary" tests -- Tests ordered by a consultant which appear to be "Medically Unnecessary" will be paid by the program. However, such tests must be documented in the appropriate log at the Referral Center.

- Railroad Retirement beneficiaries -- This group will not be eligible to obtain a second opinion through the MSSOP. Further, any beneficiary whose contract is not serviced by BCBSM will not be eligible for a second opinion consultation under the MSSOP.

- F.O.P. recommendation received before the beneficiary is eligible for Medicare coverage -- If the beneficiary's visit to his/her F.O.P. to discuss surgery occurred before his/her eligibility for Medicare coverage, the beneficiary can obtain a second opinion under the MSSOP provided he/she has a valid contract when the request is made. No more than 120 days should have elapsed between the visit and the call to the Referral Center requesting a second opinion.

- Podiatric Consultants -- For podiatric surgeries (foot surgeries), second opinions will be rendered by participating Podiatric consultants provided the F.O.P. was also a Podiatrist (D.P.M.).

- Oral Surgeons -- Doctors of Dental Surgery who are board certified Oral Surgeons will render second opinions to beneficiaries whose conditions are amenable to handling by an Oral Surgeon. For such cases, the F.O.P. must also be an Oral Surgeon.

- Surgical Advisory Committee -- It was proposed initially that a Surgical Advisory Committee be established for the MSSOP. However, as the program's developmental phase progressed it was determined that such a committee would not be needed.

- Mailing of flyers along with OASDI checks -- It was proposed initially that envelope stuffers be mailed along with the OASDI checks to beneficiaries in the Tri-County area. However, this suggestion was checked by the Project Officer and determined not feasible.

- Color coded claim form -- HCFA 1490(2) forms, color coded yellow, have been specially printed by the Government for use by the program.

- Claims submitted on SSA-1483 -- These claims will be handled using the procedure discussed in Section VIII, 101 to 105 so that the beneficiary's deductibles and copayments can be waived for the MSSOP.

X. IMPORTANCE OF MSSOP IN VIEW OF NATIONAL SECOND OPINION INITIATIVE OF DHEW

Hale Champion, Under Secretary of Health, Education and Welfare, addressed the Subcommittee on Oversight and Investigations, Committee on Interstate and Foreign Commerce, House of Representatives on November 1, 1977 and announced that the DHEW will encourage the public, and particularly the Medicare and Medicaid beneficiaries, to obtain a second opinion before undergoing elective surgery. As a result of Mr. Champion's statement, the DHEW has launched a national effort encouraging its beneficiaries to use the second opinion benefit available through their Part B and/or Medical Assistance coverage.

Prior to Mr. Champion's statement of November 1, 1977, the HCFA awarded a contract to BCBSM on September 29, 1977 to administer a demonstration program offering second/third opinions to Medicare beneficiaries residing in the Detroit Tri-County area of Michigan. BCBSM's contract for this program is one of two awarded by HCFA to implement second opinion programs in designated areas.

The availability of the MSSOP will enable the evaluator designated by HCFA to make a number of comparative and contrasting observations based on the experiences of the MSSOP in relation to the national second opinion effort. The demonstration program and the national second opinion effort should give an indication as to the best approach to take so that Medicare beneficiaries will utilize the programs available to them as much as possible.

Further, it will be possible to study the effectiveness of the various methods used to publicize the demonstration programs and the national second opinion effort. The MSSOP's approach to communicating the program to eligible beneficiaries can be compared with that used in the national second opinion effort. Perhaps the results of the comparison will contribute to the determination of the best method to employ when attempting to educate the entire beneficiary population to the merits of obtaining a second opinion.

By offering both the MSSOP and the national second opinion effort, it will be possible to determine:

- The effect of waiving copayments and deductibles on program utilization.
- The advantages and disadvantages of having a formalized Referral Center to assist beneficiaries and to schedule their appointments.
- The program which will be more readily acceptable to the medical community and to the beneficiary population.

- The program which has a greater impact in reducing surgical utilization.

- The program which demonstrates the most significant potential for cost containment while at the same time maintaining and/or enhancing quality of care.

The MSSOP and the national second opinion effort will provide the opportunity for in-depth comparative/contrasting studies of second opinions and whether such programs can be considered as viable tools to be used for the delivery and financing of health care services.

APPENDIX 1:

Grand Rapids PSRO
Tentative Phase-In Schedule - Binding Review

Location	Facility	Review Date
Grand Rapids	Blodgett Memorial (403 beds)	July 15, 1978
Grand Rapids	Butterworth (554 beds)	October 1, 1978
Grant	Grant Memorial (32 beds)	December 1, 1978
Muskegon	Muskegon General (137 beds)	July 15, 1978
Muskegon	Hackley (361 beds)	July 15, 1978
Grand Haven	North Ottawa (116 beds)	September 1, 1978
Zeeland	Zeeland Community (63 beds)	September 1, 1978
Holland	Holland Community (198 beds)	September 1, 1978
Grand Rapids	Grand Rapids Osteopathic (229 beds)	July 15, 1978
Big Rapids	Mecosta County General (74 beds)	December 1, 1978
Fremont	Gerber Memorial (87 beds)	October 1, 1978
Edmore	Tri-County Community (40 beds)	December 1, 1978
Greenville	United Memorial (106 beds)	August 15, 1978
Carson City	Carson City Memorial (107 beds)	January 1, 1979
Shelby	Lakeshore Community (35 beds)	December 1, 1978
Belding	Belding Community (56 beds)	October 1, 1978
Sheridan	Sheridan (42 beds)	October 1, 1978
Reed City	Reed City (50 beds)	August 1, 1978
Lakeview	Kelsey Memorial (94 beds)	October 1, 1978
Ionia	Ionia County Memorial (78 beds)	September 1, 1978
Hart	Oceana (43 beds)	August 1, 1978
Ludington	Memorial of Mason County (102 beds)	September 1, 1978
Grand Rapids	Ferguson-Droste-Ferguson (105 beds)	July 15, 1978
Grand Rapids	Booth Memorial (10 beds)	January 1, 1979

APPENDIX 2:

Wayne County PSRO
Public Notice - Binding Review

PUBLIC NOTICE

The Federation of Physicians/PSRO will assume full responsibility for review of health care services and items to persons eligible to receive benefits which may be paid for under the Medicare, Medicaid, Maternal and Child Health and Crippled Children's program provided in the following hospitals on the dates specified below:

Hospital	Address	Date Assuming Review
Children's Hospital of Michigan	3901 Beaubien Boulevard Detroit, Michigan 48201	July 5, 1978
Detroit Memorial Hospital	1420 St. Antoine Detroit, Michigan 48226	July 5, 1978
Doctors Hospital	2730 East Jefferson Ave. Detroit, Michigan 48207	July 5, 1978
Holy Cross Hospital	4777 East Outer Drive Detroit, Michigan 48234	July 5, 1978
Lynn Hospital	25750 West Outer Drive Lincoln Park, Michigan 48146	July 5, 1978
North Detroit General Hospital	3105 Carpenter Detroit, Michigan 48212	July 5, 1978
Riverside Osteopathic Hospital	150 Truax Street Trenton, Michigan 48183	July 5, 1978
Southwest Detroit Hospital	2401 20th Street Detroit, Michigan 48216	July 5, 1978
St. John Hospital	22101 Moross Road Detroit, Michigan 48236	July 5, 1978
St. Mary Hospital	36475 Five Mile Road Livonia, Michigan 48154	July 5, 1978
Wayne County General Hospital	2345 Merriman Road Eloise, Michigan 48132	July 5, 1978

APPENDIX 2: (Continued)

Wayne County PSRO
Public Notice - Binding Review

HOSPITAL	DELEGATED FUNCTIONS	
	Concurrent Review	M.C.E.
Children's	Full	Full
Detroit Memorial	Partial	Full
Doctors	Full	Full
Holy Cross	Full	Full
Lynn	Full	Full
Mt. Carmel	Full	Full
North Detroit General	Full	Full
Riverside Osteopathic	Full	Full
Southwest	Partial	Full
St. John	Full	Full
St. Mary	Full	Full
Wayne County	Full	Full

APPENDIX 2: (Continued)

Wayne County PSRO
Public Notice - Binding Review

The Federation of Physicians/PSRO will assume full review responsibility pursuant to an agreement with the Secretary of the Department of Health, Education and Welfare and the requirements of Title XI, Part B, of the Social Security Act (42 U.S.C. 1320 c et seq.) and regulations and guidelines thereunder.

The formal plan and timetable approved by the Secretary for assumption of review responsibilities by the Federation of Physicians/PSRO are available for public inspection by appointment. Telephone - 871-5060.

Questions may be addressed in writing to:

Mr. James L. Lang
Executive Director
The Federation of Physicians/PSRO
New Center Building - Suite 533
7430 Second Avenue
Detroit, Michigan 48202

APPENDIX 3:

Participating Agreement

REGISTRATION AND PARTICIPATION AGREEMENT
PROGRAM FOR CONSULTATION ON ELECTIVE SURGERY
BLUE CROSS AND BLUE SHIELD OF MICHIGAN

Date _____

I am a doctor of _____ licensed in Michigan. I am Board Certified in _____. My primary specialty is _____.

I hereby register as a consulting physician under the Program for Consultation on Elective Surgery being conducted by Blue Cross and Blue Shield of Michigan, and agree to accept the fee for consultation as established by Blue Cross and Blue Shield of Michigan with no additional charge to the patient.

As a consultant, I agree not to perform on the patient any surgical procedure related to the condition for which the PROCES patient was referred to me for consultation. I further agree not to refer the patient to any physician other than the First Opinion Surgeon except at the request of the patient, provided said referral does not constitute a conflict of interest as defined in the PROCES Consultant's Manual.

This registration and agreement may be terminated at any time at the option of either party by giving thirty calendar days notice in writing to the other party.

My Registration No. is_____. My date of Licensure is _____ _____. My date of Certification is _____.

My office address to which all communications from Blue Cross and Blue Shield of Michigan are to be sent is (Please type or print):

_____
Name

_____
Street

_____
City Zip County

_____
Signature of Physician Consultant

APPENDIX 4:

Addendum Agreement

ADDENDUM

REGISTRATION AND PARTICIPATION AGREEMENT
PROGRAM FOR CONSULTATION ON ELECTIVE SURGERY
BLUE CROSS AND BLUE SHIELD OF MICHIGAN

This document extends the participation of those who have registered as consulting physicians under the Program for Consultation on Elective Surgery to any program conducted by Blue Cross and Blue Shield of Michigan which offers second opinions relating to elective surgery.

Physicians, who accept a covered member for a second or third opinion consultation under a second opinion program, agree to comply with the terms and conditions as set forth in the Consultant's Manual for that program.

☐ I agree to this extension ☐ I do not agree to this extension

Name

Address

City and State

Signature of Physician Date

APPENDIX 5:

BCBSM Position on Professional Liability Coverage

ADDENDUM TO CONSULTANT'S MANUAL
PROGRAM FOR CONSULTATION ON ELECTIVE SURGERY
PROFESSIONAL LIABILITY

Blue Cross and Blue Shield of Michigan has had discussions with professional liability carriers as well as with the Bureau of Insurance of the State of Michigan. The Bureau advises us that all current professional liability contracts include coverage for misadventures in consultations, inclusive of those occurring in surgical second opinion programs. We are also advised that the current premiums include such liability; therefore, no carrier would have occasion to increase the premium for participating consultants.

For physicians who agree to participate as consultants in Blue Cross and Blue Shield of Michigan conducted surgical second opinion programs, Blue Cross and Blue Shield of Michigan will commit to payment of the surcharge differential and/or replacement premium differential for comparable coverage, for a period of up to three policy years from the date of such action, if such surcharge and/or cancellation is occasioned by a professional liability claim involving a consultation in any Blue Cross and Blue Shield of Michigan second opinion program conducted through its second opinion Referral Center.

Blue Cross and Blue Shield of Michigan will not commit to assumption of any liability for participating consultants who do not have professional liability coverage.

APPENDIX 6:

Letter of Invitation to Eligible Surgeons

In July, 1977 Blue Cross and Blue Shield of Michigan implemented a Surgical Second Opinion Pilot Study called the Program for Consultation on Elective Surgery (PROCES) which covers Auto employees, retirees, surviving spouses, and eligible dependents who work/reside in Wayne, Oakland, and Macomb counties. Further, since January, 1978, employees and their dependents of Michigan Bell and the U.A.W. Staff Groups have received a surgical second opinion benefit similar to that provided by the Auto Pilot Study. Blue Cross and Blue Shield of Michigan has also been awarded a contract to conduct a Surgical Second Opinion demonstration program for Medicare beneficiaries in the tri-county area beginning in August, 1978.

A key component of all these programs is the recruitment of highly qualified surgical consultants who will provide the second opinions. Some of you, who are eligible, may not have received my previous invitation to serve as a consultant. As a result, after updating our mailing list, I am extending an invitation to you to participate as a consultant in these programs.

In all of these programs the eligible patient will be provided with a free choice of a consultant convenient to the job site or home, and the appointment will be scheduled by BCBSM. The program is completely voluntary on the part of the patient and the member has the right to accept or reject the consultant's decision without any loss of benefits.

To qualify as a consultant in the tri-county area, a doctor must be a Board Certified M.D., a Certified Specialist D.O., a Diplomate of the American Board of Oral Surgery or Board Certified by the American Board of Podiatric Surgery. A consultant must agree not to perform the surgery or treat the patient for the condition for which the second opinion is obtained. Reimbursement for the consultation will be on a reasonable and customary basis up to a $50 ceiling, and ancillary studies will be paid which are necessary to evaluate the surgery, as the next therapeutic step.

Some physicians have expressed a concern about professional liability implications for program consultants. Be assured that BCBSM has thoroughly considered this issue, and you will find attached a copy of the BCBSM position on professional liability, which should alleviate any concern you may have.

Should you elect to become one of our consultants, you will be providing second opinion consultations for patients covered by any second opinion program conducted by Blue Cross and Blue Shield of Michigan. However, be assured that the Referral Center will not overburden your schedule.

APPENDIX 6: (Continued)

Letter of Invitation to Eligible Surgeons

We will be pleased to send you any additional information that you would like on these programs, and I hope that you will agree to serve as a consultant to meet the growing interest of the Public in surgical second opinions.

Enclosed is a prepaid postcard on which you may indicate your response to this invitation.

I remain

Sincerely,

Louis F. Hayes, M.D.
Vice President
Professional Affairs Group

LFH:mao

Enclosures (2)

APPENDIX 7:

Letter of Invitation to Current Consultants

As a consultant for the Program for Consultation on Elective Surgery, I want to advise you of some recent developments.

First, in June of 1977, I sent a letter to currently participating and potentially participating consultants in the PROCES Program -- addressing the issue of professional liability. In that letter was a commitment by BCBSM to accept liability for costs and settlements involved in litigations arising out of consultations in the PROCES Program -- if not covered by their current professional liability.

Subsequent to that letter, several consultants reported that there was yet an unmet need. They felt that, while their professional liability carriers would have liability for an incident arising out of a consultation in the PROCES Program, the potential existed for surcharges for subsequent years and/or cancellation of their contract -- by their current carrier. For that reason, BCBSM has had discussions with professional liability carriers as well as the Bureau of Insurance of the State of Michigan. BCBSM has thoroughly considered this issue and has taken a position which should alleviate your concerns. This position is reflected in the enclosed attachment which is to be added as an addendum to your PROCES Consultant's Manual.

Further, beginning in January, 1978, employees and their dependents of the Michigan Bell and U.A.W. Staff Groups have received a surgical second opinion benefit. In addition, BCBSM has been awarded a contract by the Health Care Financing Administration of the Department of Health, Education and Welfare to conduct a surgical second opinion program for Medicare beneficiaries in the tri-county area. This latter program will be implemented in August, 1978. The terms and conditions for consultants participating in the second opinion program for Medicare beneficiaries and Bell and U.A.W. employees are similar to the Auto PROCES Program, but separate Consultant's Manuals will be provided to clarify eligibility of the members, etc.

An addendum to the participating agreement for consultants is attached to extend the agreement to other second opinion programs. Your acknowledgment of this extension is requested by returning the original of the addendum with your signature in the enclosed postage paid envelope.

The service you have been providing as a consultant is greatly appreciated by the covered members and Blue Cross and Blue Shield of Michigan.

APPENDIX 7: (Continued)

Letter of Invitation to Current Consultants

Should you have any questions, contact the Referral Center or myself.

I remain,

Sincerely,

Louis F. Hayes, M.D.
Vice President
Professional Affairs Groups

LFH:mao

Enclosure

APPENDIX 8:

Follow-up to Letter of Invitation to Eligible Surgeons

Dear Doctor:

Thank you for your expression of interest in our surgical second opinion programs. Enclosed you will find:

1. The Participating Agreement and Addendum for your signature.

2. The Consultant's Manual for the Program for Consultation on Elective Surgery (PROCES) which is the second opinion program covering tri-county Auto workers, and

3. The Consultant's Manual for the Medicare Surgical Second Opinion Program (MSSOP) which is a demonstration program for beneficiaries residing in the tri-county area.

The Consultant's Manual for the other second opinion programs, such as Michigan Bell which is essentially the same as the Auto program, will be forwarded to you shortly.

Your signature on the Participating Agreement and the Addendum will indicate that you will abide by the terms and conditions contained in the Consultant Manuals.

Please complete and sign the Participating Agreement and Addendum, retain the carbon copies and return the signed originals in the enclosed prepaid envelope to the BCBSM Referral Center as soon as possible.

Although we cannot predict the minimum number of consultations which will be referred to you each month, be assured that the BCBSM Referral Center will arrange consultation appointments so as not to overburden your schedule.

Some personal contact between the program consultants and the Referral Center staff may be arranged in the future to exchange views and to resolve any problems which might arise.

If you have further questions, please call:

(313) 225-0234

or you may write to:

Referral Center, J713
Blue Cross and Blue Shield of Michigan
600 Lafayette East
Detroit, Michigan 48226

APPENDIX 8: (Continued)

Follow-up to Letter of Invitation to Eligible Surgeons

We again thank you for your interest and look forward to you becoming a consultant to our second opinion programs.

Sincerely,

Louis F. Hayes, M.D.
Vice President
Professional Affairs Group

LFH:mao

Enclosures

APPENDIX 9:

Physician's Reply Card

TO: REFERRAL CENTER

☐ I AM INTERESTED IN THE SECOND OPINION PROGRAMS CONDUCTED BY BCBSM. PLEASE SEND ME THE REGISTRATION AND PARTICIPATION AGREEMENT.

☐ I AM NOT INTERESTED BECAUSE _____

_____

_____
SIGNATURE

PLEASE PRINT NAME _____

ADDRESS _____

TELEPHONE NUMBER _____

BCBSM PROVIDER CODE _____

DATE _____

5518-6 MAR 78

BUSINESS REPLY MAIL
NO POSTAGE NECESSARY IF MAILED IN THE UNITED STATES

POSTAGE WILL BE PAID BY —

Referral Center #J713
Blue Cross and Blue Shield of Michigan
600 Lafayette East
Detroit, Michigan 48226

FIRST CLASS
PERMIT NO.
6431
DETROIT, MICH.

APPENDIX 10:

Suggested Article for Newsletter

SECOND OPINIONS AVAILABLE FOR TRI-COUNTY MEDICARE BENEFICIARIES

Public concerns are mounting about the amount of surgery being performed in the United States -- surgeries have been increasing rapidly since 1971 disproportionate to increases in the general population.

During the Congressional hearings on unnecessary surgery in 1975 and 1977, it was reported that as many as 2.38 million unnecessary surgeries were performed in 1974. This contrasts with claims that unnecessary surgeries are miniscule. Despite the debate, it is generally agreed that some amount of unnecessary surgery is occurring.

One way which has been suggested to help individuals avoid unnecessary surgery is to obtain a second opinion. Doctors and patients have often sought second opinions in the past. The concept is not new. However, the cost of obtaining the second opinion has sometimes been an obstacle. Now, that obstacle has been removed, particularly for Medicare beneficiaries in Wayne, Oakland and Macomb counties.

Beginning August 1, 1978, Medicare beneficiaries in the Detroit tri-county area will be able to obtain second/third opinion consultations for non-emergency surgery. Costs for the consultation, and any tests performed by the consultant, will be paid for by a new demonstration program -- the Medicare Surgical Second Opinion Program. This new program will be administered under the auspices of the Health Care Financing Adminstration, U.S. Department of Health, Education and Welfare.

Beneficiaries can obtain a second opinion under their Medicare Medical Insurance Coverage (Part B). However, the 20 percent copayment and the $60 yearly deductible are the responsibility of the beneficiary. Under the new demonstration program, however, the copayments and deductibles will be paid by the program provided that the second opinion appointment is arranged through the Referral Center located at Blue Cross and Blue Shield of Michigan.

To obtain a second or even a third opinion through this demonstration program, an eligible beneficiary simply calls the Referral Center at (313) 225-0112. The nurse-analyst at the center will give the caller names of board-certified surgeons. The beneficiary, in turn, chooses the consultant he or she wishes to see. The analyst will make the appointment for the beneficiary.

APPENDIX 10: (Continued)

Suggested Article for Newsletters

The demonstration program is entirely optional -- that is, it is up to the individual to obtain a second opinion consultation. Regardless of the consultant's recommendation the beneficiary's surgery will be paid for if he or she decides to have the surgery.

By receiving a second or third opinion, a beneficiary will have additional information on which to base a decision. Further, the consultant may be able to suggest an alternative method of treatment.

If you want more information about the program -- or want to make a second opinion appointment, call the BCBSM Referral Center at (313) 225-0112.

APPENDIX 11:

Letterhead with Program Identity Symbol

LOUIS F. HAYES, M.D., VICE PRESIDENT, PROFESSIONAL AFFAIRS • ANN SIMPSON, MANAGER, MEDICAL PLANNING & DEVELOPMENT DEPT.
ALEX CARAGAY, ADMINISTRATOR, 2ND OPINION REFERRAL CENTER • (313) 225-0112 • 600 LAFAYETTE EAST, DETROIT, MICHIGAN 48226

APPENDIX 12:

MSSOP Brochure

THINKING ABOUT SURGERY?

GET A SECOND OPINION!

Blue Cross
Blue Shield
of Michigan

APPENDIX 12: (Continued)

MSSOP Brochure

INTRODUCTION . . .

Starting August 1, 1978, many people on Medicare in the tri-county area will be able to get a second or third doctor's opinion on non-emergency surgery. The service is offered at no cost. It's part of a demonstration program sponsored by the U.S. Department of Health, Education and Welfare. The program is administered by Blue Cross and Blue Shield of Michigan.

WHAT DOES THE SECOND-OPINION PROGRAM MEAN TO ME?

It means that — if you're eligible — you can get more information from another doctor to help you decide about surgery.

DOES THE PROGRAM HAVE ANY SPECIAL FEATURES?

Yes, and they're designed to save you time, trouble and money while giving you peace of mind. Second opinions are already available as part of your regular Medicare Part B benefits — but you must meet your deductibles and pay 20 percent of the charges. But, if you use this demonstration program, a Referral Center at Blue Cross and Blue Shield of Michigan will make an appointment for you with a program consultant of your choice. You will be able to choose from several Board Certified surgical specialists who have agreed to provide second opinions for this program — and you won't have to pay for deductibles and copayments if you arrange your appointment through the Referral Center.

APPENDIX 12: (Continued)

MSSOP Brochure

AM I ELIGIBLE?

Yes, if you . . .

- live in Wayne, Oakland or Macomb counties
- have a Medicare card with hospital and medical insurance serviced by Blue Cross and Blue Shield of Michigan
- talked to your doctor in the past four months about surgery to be done at a hospital or surgical facility and
- arrange your appointment through the Referral Center.

WHAT IS NON-EMERGENCY SURGERY?

Generally, it's an operation you have done at the convenience of you and your doctor. Examples include hernia operations, disc surgery, hysterectomies, cataract surgery, foot operations and the like.

WHAT IS THE REFERRAL CENTER?

The Referral Center helps you to get involved in the program with a simple phone call to 225-0112. You set the program in motion by phoning the Center for a second opinion. They'll ask you for certain kinds of information, including your Medicare number, to find out whether you're eligible. If you're eligible, they'll give you the names of surgical consultants near you so you can decide who you want to see.

So the consultant won't have to repeat diagnostic tests you've already had, the Center will ask your permission to call your doctor

APPENDIX 12: (Continued)

MSSOP Brochure

for information to be given to the consultant. But it is up to you to decide. The Referral Center won't contact your doctor unless you agree.

HOW DO I MAKE AN APPOINTMENT?

The Center takes care of that for you. You just let them know which doctor you prefer from names the Center gives you.

WHAT'S THE NEXT STEP?

You keep your appointment. The consulting doctor may examine you and order tests or X-rays. You do not have to pay for most tests ordered by the consultants — not even the Medicare copayments and deductibles. However, if the tests are not normal Medicare benefits, you will have to pay for them. The consulting doctor will tell you if the tests are covered by your Medicare. Once your test results are in and your examination is completed the doctor will give his opinion.

SUPPOSE I STILL CAN'T DECIDE?

If you still think you need more information to decide, ask for a third opinion by calling the Referral Center.

WILL MEDICARE PAY FOR THE OPERATION IF I DON'T FOLLOW THE CONSULTANT'S RECOMMENDATION?

Yes. Whatever you decide to do, after your second or third opinion consultation, your Medicare benefits will still pay for the surgery.

APPENDIX 12: (Continued)

MSSOP Brochure

WILL I HAVE TO PAY FOR ANYTHING AT ALL?

As mentioned earlier, you won't have to pay for tests which are part of your normal Medicare benefits. But, if the consultant puts you in the hospital as a bed patient for testing, you will have to pay the normal inpatient hospital copayments and deductibles, unless you have other insurance that will cover them. Other than this, you won't have to pay for the consultation or tests if your consultation is arranged by the Referral Center.

SUPPOSE I HAVE QUESTIONS ABOUT PAYMENTS?

If you are billed for any service related to the consultation, call the Referral Center and let them know. If it's something you should not have paid for, they'll ask you to send them your receipt. You will get your money back.

FOR ANY QUESTIONS ABOUT A SECOND OPINION

Call the Referral Center at 225-0112.

APPENDIX 13:

MSSOP Poster

THINKING ABOUT SURGERY?

GET A SECOND OPINION!

SURGERY IS AN IMPORTANT STEP.

If your doctor has discussed a non-emergency operation with you, you may want to hear what a second or even a third doctor would recommend.

Medicare will pay for the second or third surgical opinion — at no cost to you.

To qualify, you must have Medicare hospital and medical coverage that is serviced by Blue Cross and Blue Shield of Michigan. You also must live in Wayne, Oakland or Macomb Counties.

You set the program in motion by calling the Referral Center at 225-0112. They'll name highly qualified consulting doctors near you. You choose one and the Center makes an appointment for you.

For more details, call 225-0112. It costs you nothing.

medicare 2nd opinion

CONDUCTED BY BLUE CROSS AND BLUE SHIELD OF MICHIGAN UNDER THE AUSPICES OF THE HEALTH CARE FINANCING ADMINISTRATION OF THE U.S. DEPARTMENT OF HEALTH, EDUCATION AND WELFARE.

Blue Cross
Blue Shield
of Michigan

APPENDIX 14:

MSSOP Envelope Stuffer

THINKING ABOUT SURGERY?

GET A SECOND OPINION!

Blue Cross Blue Shield of Michigan

HOW TO GET A SECOND OPINION ABOUT SURGERY

. . . if you're on Medicare

* If you've discussed non-emergency surgery with your doctor, Medicare will pay for the costs of a second or third doctor's opinion about your surgery.
* Examples of non-emergency surgery include cataract operations, foot surgery, hysterectomies, hernia repairs, disc surgery and others that can be done at the convenience of you and your doctor.

(over)

* To qualify you must . . .
  - have a Medicare card with hospital and medical coverage which is serviced by Blue Cross & Blue Shield of Michigan and
  - live in Wayne, Oakland or Macomb counties
* Surgery is an important step. You may want more information from a second or third doctor to help you make up your mind.
* Not only does the program pay for surgical advice, but it also has a Referral Center staffed by nurses to assist you. They can make an appointment for you with a Board Certified surgical consultant that you choose from the names given.
* You and you alone make the decision — and your Medicare benefits aren't affected either way. For example, let's say the consultant doctor suggests no surgery — if you decide to have the operation anyway, then it's still covered by Medicare.
* For further information or to make your appointment call the Referral Center at 225-0112.

CONDUCTED BY BLUE CROSS AND BLUE SHIELD OF MICHIGAN UNDER THE AUSPICES OF THE HEALTH CARE FINANCING ADMINISTRATION OF THE U.S. DEPARTMENT OF HEALTH, EDUCATION AND WELFARE

4013-9 MAY 78

37

APPENDIX 15:

MSSOP Wallet Card

FOR INFORMATION ON MEDICARE SURGICAL SECOND OPINION

Call: (313) 225-0112

ADDRESS: Referral Center J713
Blue Cross and Blue Shield of Michigan
600 Lafayette East
Detroit, Michigan 48226

EMERGENCY IDENTIFICATION CARD

NAME _____ TELEPHONE _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

BIRTHDATE _____ BLOOD TYPE _____

ALLERGIES _____

MEDICATION _____

PHYSICIAN _____ TELEPHONE _____

IN EMERGENCY CONTACT _____

TELEPHONE _____

4014-7 MAY 78

APPENDIX 16:

Announcement Letter to Area Physicians

TO: DOCTORS PRACTICING IN THE DETROIT TRI-COUNTY AREA

SUBJECT: MEDICARE SURGICAL SECOND OPINION PROGRAM

This letter is written to advise you of the forthcoming implementation of a demonstration program which will make available second and third opinion consultations for Medicare beneficiaries in Wayne, Oakland, and Macomb counties. It is being administered by Blue Cross and Blue Shield of Michigan (BCBSM) under a contract with the Health Care Financing Administration (HCFA), U.S. Department of Health, Education and Welfare.

While ambulatory second opinions are currently a Medicare benefit, the beneficiary is responsible for the normal Medicare deductible and copayments when utilizing the benefit. For this demonstration program, however, the deductible and copayments are waived so that the consultant's fee and any related ancillary tests for second and third opinions will be paid in full by Medicare. The demonstration program also differs from the benefit in that the BCBSM Referral Center will make the beneficiary's appointment with the consultant whom the beneficiary selects.

Beginning August 1, 1978, second and third opinion consultations will be available through this demonstration program until July 31, 1981. During this time, beneficiaries in the tri-county area will be able voluntarily to obtain a second opinion on elective surgery, whether the surgery was recommended or not recommended by the beneficiary's attending physician. The beneficiary will not be compelled to follow the recommendation of the program consultant, and Medicare hospital and medical benefits will be paid if he/she decides to undergo surgery, regardless of the consultant's opinion.

As in our other second opinion programs, the consultants, recruited through letters of invitation, are Board Certified M.D.s, Certified Specialist D.O.s, and Board Certified Oral Surgeons, D.D.S. In addition, there are a number of Board Certified Podiatric Surgeons who serve as consultants for podiatric cases.

To obtain an ambulatory surgical second and even a third opinion consultation, the beneficiary simply telephones the Referral Center located at Blue Cross and Blue Shield of Michigan at (313) 225-0112. A Registered Nurse at the Referral Center will provide the beneficiary with the names of several appropriate surgical specialists. The beneficiary chooses the consultant, and the Referral Center arranges the appointment for the beneficiary.

APPENDIX 16: (Continued)

Announcement Letter to Area Physicians

The Health Care Financing Administration will be awarding a contract, through competitive bidding, to evaluate Michigan's demonstration program, another Medicare demonstration program in New York City, and a Medicaid demonstration in Massachusetts, as well as HEW's efforts to promote the use of second opinions nationally by those covered by Medicare and Medicaid. This evaluation will attempt to determine the effects of optional second and third opinions on the quality of surgical care and the costs to the Medicare and Medicaid programs.

Should one of your patients request a second opinion through this program, your role would be extremely important, although minimal in terms of the time and effort required: We request:

- Your support to this program. This would be reassuring to the beneficiary should he/she express a desire to use the program after you have discussed elective surgery with him/her.

- Your assistance in assuring the beneficiary that the necessary records and test results will be forwarded to the consultant to avoid duplication of tests already performed.

- Your cooperation in completing a simple form stating principally the diagnosis, medical findings, test results, and the surgical procedure discussed. This form can be completed either directly over the telephone or through the mail. All we request is that the form be completed promptly so that it can be forwarded to the beneficiary's program consultant prior to the scheduled consultation date.

We will be pleased to answer any questions you may have about the Medicare Surgical Second Opinion Program. For further information on the demonstration program, or if you wish to make program brochures available to your patients, you may write to:

Referral Center, J713
Blue Cross and Blue Shield of Michigan
600 Lafayette East
Detroit, Michigan 48226

or you may call (313) 225-0234.

Sincerely,

Louis F. Hayes, M.D.
Vice President
Professional Affairs

APPENDIX 17:

Announcement Letter to Area Hospitals, Nursing Homes

TO: ADMINISTRATORS OF BLUE CROSS AND BLUE SHIELD OF MICHIGAN PARTICIPATING HOSPITALS AND ADMINISTRATORS OF SKILLED NURSING FACILITIES

SUBJECT: IMPLEMENTATION OF MEDICARE SURGICAL SECOND OPINION DEMONSTRATION PROGRAM

This letter is written to advise you of the forthcoming implementation of a demonstration program which will make available second and third opinion consultations for Medicare beneficiaries in Wayne, Oakland and Macomb counties. It is being adminstered by Blue Cross and Blue Shield of Michigan (BCBSM) under a contract with the Health Care Financing Administration (HCFA), U.S. Department of Health, Education and Welfare.

While ambulatory second opinions are currently a Medicare benefit, the beneficiary is responsible for the normal Medicare deductible and copayments when utilizing the benefit. For this demonstration program, however the deductible and copayments are waived so that the consultant's fee and any related ancillary tests for second and third opinions will be paid in full by Medicare. The demonstration program also differs from the benefit in that the BCBSM Referral Center will make the beneficiary's appointment with the consultant whom the beneficiary selects.

Beginning August 1, 1978, second and third opinion consultations will be available through this demonstration program until July 31, 1981. During this time, beneficiaries in the tri-county area will be able voluntarily to obtain a second opinion on elective surgery, whether the surgery was recommended or not recommended by the beneficiary's attending physician. The beneficiary will not be compelled to follow the recommendation of the program consultant, and Medicare hospital and medical benefits will be paid if he/she decides to undergo surgery, regardless of the consultant's opinion.

As in our other second opinion programs, the consultants, recruited through letters of invitation, are Board Certified M.D.s, Certified Specialist D.O.s, and Board Certified Oral Surgeons, D.D.S. In addition, there are a number of Board Certified Podiatric Surgeons who serve as consultants for podiatric cases.

To obtain an ambulatory surgical second and even a third opinion consultation, the beneficiary simply telephones the Referral Center located at Blue Cross and Blue Shield of Michigan at (313) 225-0112. A Registered Nurse at the Referral Center will provide the beneficiary with the names

APPENDIX 17: (Continued)

Announcement Letter to Area Hospitals, Nursing Homes

of several appropriate surgical specialists. The beneficiary chooses the consultant, and the Referral Center arranges the appointment for the beneficiary.

The Health Care Financing Administration will be awarding a contract, through competitive bidding to evaluate Michigan's demonstration program, another Medicare demonstration program in New York City, and a Medicaid demonstration in Massachusetts, as well as HEW's efforts to promote the use of second opinions nationally by those covered by Medicare and Medicaid. This evaluation will attempt to determine the effects of optional second and third opinions on the quality of surgical care and the costs to the Medicare and Medicaid programs.

All claims, whether reported on Medicare claim forms 1490 or 1483, are to be sent to the Referral Center for special handling in order to waive the copayments and deductibles. A separate bulletin to hospitals will be issued providing instructions on billing ancillary tests ordered by a consultant from a hospital and reported on claim form 1483.

Any assistance you may be able to provide in publicizing the Medicare Surgical Second Opinion demonstration program to your staff and to the communities you serve will be appreciated. If you wish to obtain posters to display at your facility, brochures to be placed in your "Take One" rack, or more information on the program, you may call (313) 225-0234 or write to:

Referral Center, J713
Blue Cross and Blue Shield of Michigan
600 Lafayette East
Detroit, Michigan 48226

Sincerely,

Louis F. Hayes, M.D.
Vice President
Professional Affairs Group

APPENDIX 18:

Announcement Letter to Organizations, Groups and Agencies Related to Senior Adults

Dear Community Leader:

I am writing to advise you of a new demonstration program for Medicare beneficiaries in Wayne, Oakland and Macomb counties because I know that you will want to be aware of this program and be able to advise those older adults with whom you are in contact.

NEW PROGRAM FOR MEDICARE BENEFICIARIES

On August 1, 1978, a demonstration program called the Medicare Surgical Second Opinion Program (MSSOP) will be implemented. It is being administered by Blue Cross and Blue Shield of Michigan under a contract with the Health Care Financing Administration (HCFA), U.S. Department of Health, Education and Welfare. It will make available to Medicare beneficiaries in Wayne, Oakland and Macomb counties a second and third surgical opinion for those beneficiaries who have discussed elective surgery with their doctor. An article is attached to this letter which more fully describes the program and how it operates.

REASONS FOR PROGRAM

Public concern has been voiced about the rate of surgery in the United States which has been increasing in recent years and is considerably higher than in many other countries. In a statement made before the Congressional Subcommittee on Oversight and Investigations last November, Under Secretary of Health, Education and Welfare, Hale Champion, announced that HEW was going "to begin a major effort to encourage the American public, and especially our own beneficiaries immediately to seek second opinions." One of the ways this is being done is through the implementation of this demonstration program. Both HEW and Blue Cross and Blue Shield of Michigan are aware of the need for an intensive consumer education program to inform beneficiaries of the availability and advantages of surgical second opinions.

EDUCATIONAL MATERIALS AVAILABLE

Blue Cross and Blue Shield of Michigan has developed a number of materials to assist agencies and organizations to inform Medicare beneficiaries about the program. Of course, we will be initiating efforts of our own, such as TV and radio "spot" announcements to inform the public about the program. But we sincerely believe that the most meaningful approach to help the beneficiaries to understand and use the program is through organizations such as yours. It is for that reason that I write and request your support and assistance.

APPENDIX 18: (Continued)

Announcement Letter to Organizations, Groups and Agencies Related to Senior Adults

Among the materials we have developed are brochures and posters. The full list of these materials is attached to this letter so that you can advise us about which ones you would like to obtain. The attached article describing the program is sent to you for information, but also to provide you with a release to include in a newsletter in the event that you publish one.

YOUR ASSISTANCE REQUESTED

Your assistance and support to inform Medicare beneficiaries about this program will be greatly appreciated.

If you have any questions or suggestions, we would like to hear from you. You can contact either Mrs. Ann Simpson, Operational Manager for the Medicare Surgical Second Opinion Program, at 225-9652 or Mr. Alex Caragay, Administrator of the Referral Center, at 225-0234, or you may write them in care of Blue Cross and Blue Shield of Michigan, 600 Lafayette East, Detroit, Michigan 48226.

We will be looking forward to working with you to make this program a great success.

Sincerely,

Louis F. Hayes, M.D.
Vice President
Professional Affairs Group

LFH:mao

Enclosures (2)

APPENDIX 19:

MSSOP "Needs" Survey

2nd OPINION SERVICES REQUEST FORM

A number of publications and special services are being offered to community groups in conjunction with the Medicare Surgical Second Opinion Program sponsored by the Department of Health, Education and Welfare in association with Blue Cross and Blue Shield of Michigan. If you head an organization offering services to senior citizens, you can obtain them on a free-loan basis or as an outright donation for distribution to your members or to use in special programs. In order to obtain the materials and/or services, please complete the form below, checking materials required:

ITEM	QUANTITY
___ Poster (limit of 5)	_____
___ 2nd Opinion medical emergency wallet cards	_____
___ Information brochure	_____
___ Program manual	_____

Services:

___ A 17-minute sound slide program explaining the Second Opinion Program is available. Please indicate three preferred dates for viewing and estimated audience expected. Preferred Dates: _____ _____ Estimated Audience: _____ Time: _____ Location: _____

___ A limited number of speaking engagements can also be filled by persons knowledgeable in the program. Please indicate three preferred dates, estimated audience and the time and location of the event. Preferred Dates: _____ Estimated Audience: _____ Time: _____ Location: _____

___ My organization prints a newsletter for circulation to members. I would ____ would not ____ like to receive news releases describing the Second Opinion Program in the future.

APPENDIX 19: (Continued)

MSSOP "Needs" Survey

Name: _____ (please print) _____ (title)

_____ (street address) _____ (name of organization)

_____ (city) (zip code) _____ (telephone number)

Return this completed form to:

REFERRAL CENTER
J-713
BLUE CROSS AND BLUE SHIELD OF MICHIGAN
600 Lafayette East
Detroit, Michigan 48226

APPENDIX 20:

MSSOP Description Booklet

PROGRAM DESCRIPTION

A Demonstration Program
conducted by

BLUE CROSS AND BLUE SHIELD OF MICHIGAN

under the auspices of

THE HEALTH CARE FINANCING ADMINISTRATION
of the
U.S. DEPARTMENT OF HEALTH, EDUCATION AND WELFARE

APPENDIX 20: (Continued)

MSSOP Description Booklet

MEDICARE SURGICAL SECOND OPINION PROGRAM
(August 1, 1978 to July 31, 1981)

Purpose of the Booklet

This booklet contains a description of the Medicare Surgical Second Opinion Program conducted by Blue Cross and Blue Shield of Michigan under the auspices of the Health Care Financing Administration of the U.S. Department of Health, Education and Welfare. It will serve as an information source for: physicians in general; program consultants; other professionals and providers of health care; representatives of health care oriented organizations and groups interested in second opinion programs; and agencies, organizations, and groups involved in services for older adults.

APPENDIX 20: (Continued)

MSSOP Description Booklet

PROGRAM DESCRIPTION
MEDICARE SURGICAL SECOND OPINION PROGRAM

TABLE OF CONTENTS

	PAGE
I. Background	1
II. Purpose of the Demonstration Program	1
III. Program Description	1
A. General Provisions	1
B. Experimental Area	2
C. Eligibility	2
D. Participation	2
E. Type of Consultations Available	2
F. Surgical Procedures for Which Consultations Can Be Obtained	2
G. Qualifications of Consultants	3
H. Recruitment of Consultants	3
I. Responsibilities of Consultants	3
J. Where Consultations Can Be Obtained	4
K. The Referral Center	4
L. Scheduling the Second Opinion Consultation Appointment	4
M. Scheduling the Third Opinion Consultation Appointment	5
N. Cost of the Consultation	5
O. Diagnostic Services	5
P. Confidentiality	5
Q. Other	5
IV. Further Information	6

APPENDIX 20: (Continued)

MSSOP Description Booklet

MEDICARE SURGICAL SECOND OPINION PROGRAM
BLUE CROSS AND BLUE SHIELD OF MICHIGAN

I. Background

Blue Cross and Blue Shield of Michigan (BCBSM) has been awarded a contract to conduct a surgical second opinion demonstration program under the auspices of the Health Care Financing Administration (HCFA), U.S. Department of Health, Education and Welfare.

Further, the U.S. Department of Health, Education and Welfare (HEW) is currently developing an approach to encourage the American Public, and especially its own beneficiaries, to seek second opinions prior to elective surgery. Details about the mechanics of the national program are still being worked out by HEW. Blue Cross and Blue Shield of Michigan will try to inform those interested in the national program of new developments as they evolve.

The primary difference between the demonstration program administered by BCBSM and the national effort being designed by HEW, from a standpoint of reimbursement, is that beneficiaries covered under the demonstration have no coinsurance or deductible liability for the consultant's fee or any of the radiology and laboratory services ordered by the consultant.

The results of the BCBSM demonstration program will be used by HEW to determine whether second opinion coverage improves the quality of health care while helping to contain its costs.

II. Purpose of the Demonstration Program

The purpose of the Medicare Surgical Second Opinion demonstration program is to provide second or third surgical opinions so that an evaluation can be conducted by HCFA to determine the effects of optional, second/third opinions on the quality of surgical care, on surgical utilization, on morbidity and mortality rates, and on surgical costs to the Medicare Program.

III. Program Description

A. General Provisions

This demonstration program will provide appointments for second

APPENDIX 20: (Continued)

MSSOP Description Booklet

and third opinions with Board Certified surgeons. The appointments will be scheduled by the Referral Center when requested by a Medicare beneficiary in the experimental (treatment) area. The cost of the consultation and tests ordered by the consultant will be paid for by Medicare, with no beneficiary deductibles and copayments, when the appointment is made by the Referral Center.

B. Experimental Area

The Michigan counties of Wayne, Oakland, and Macomb (the Detroit tri-county area) comprise the experimental area in which Medicare beneficiaries will be able to obtain consultations through the BCBSM Medicare Surgical Second Opinion demonstration program without liability for copayments and deductibles.

C. Eligibility

Any Medicare beneficiary with Part B coverage who resides in the Detroit tri-county area and who, within the prior 120 days, has discussed having surgery with his/her doctor can request a second/third opinion through the BCBSM Referral Center. The visit to the doctor must be related to the condition for which the beneficiary is requesting the second/third opinion consultation.

D. Participation

The eligible beneficiary may freely choose whether or not to initiate a request for a second/third opinion consultation relating to elective surgery through the demonstration program. Regardless of the consultant's second or third opinion, the beneficiary decides whether or not to have the surgery and the surgery will be paid by Medicare.

E. Type of Consultations Available

Under this program, second and third surgical opinion consultations provided by participating surgical consultants on surgery as the next treatment step and including any radiology or laboratory tests needed by the consultant to make an assessment are available to eligible beneficiaries.

F. Surgical Procedures for Which Consultations Can Be Obtained

Second/third opinion consultations can be obtained for any non-emergency (elective) surgical procedures, except:

- Surgeries performed in the doctor's office
- Surgeries performed as a result of trauma

APPENDIX 20: (Continued)

MSSOP Description Booklet

- All normal vaginal deliveries
- Abortions
- Medicare contract exclusions.

For this demonstration program, an elective surgery is defined as surgery performed on an inpatient or outpatient hospital basis or in a free standing ambulatory surgical center and which is not considered an emergency or life threatening but subject to the choice or decision of the patient or physician. It does not imply any judgement as to medical necessity or deferrability.

G. Qualifications of Consultants

The consultants are board certified surgeons in specialties appropriate to the needs of the program who are practicing in the Detroit tri-county area. They may be either Doctors of Medicine (M.D.), or Doctors of Osteopathic Medicine (D.O.). In addition, there are Oral Surgeons (D.D.S.) and Podiatrists (D.P.M.) who provide consultations for oral surgery and podiatric surgery respectively. All consultants for the demonstration program must have professional liability coverage, must sign the Participation Agreement, and must agree to comply with the terms and conditions contained in the Consultant's Manual.

H. Recruitment of Consultants

Consultants are recruited either through letters of invitation to doctors who meet the qualifications of the program in specialties appropriate to the needs of the program, or through a local specialty society which has agreed to assist in the recruitment of consultants.

I. Responsibilities of Consultants

All participating consultants are required to agree to the following:

- That they and their associates shall not render the surgical service to the beneficiary for whom they have provided a second/third opinion under this program.
- That they shall personally examine the beneficiary, discuss their recommendations with the beneficiary, and complete the Consultant's Report for the Referral Center.
- That they shall refer the beneficiary back to the care of the original physician, unless the beneficiary specifically requests referral to another doctor. Such referrals must not constitute a conflict of interest and must be documented with the BCBSM Referral Center.

APPENDIX 20: (Continued)

MSSOP Description Booklet

- That they shall accept the consultation fee as set forth by the program as payment in full for their professional services, with no additional charges to the beneficiary.
- That they shall comply with the terms and conditions set forth in the Consultant's Manual for this program.

J. Where Consultations Can Be Obtained

Second/third opinion consultations can be obtained only in Wayne, Oakland, and Macomb counties of Michigan. Appointments must be arranged through the Referral Center located at BCBSM.

K. The Referral Center

As the "nerve center" of the second opinion program, the Referral Center's function is to arrange appointments with appropriate surgical consultants, to gather information necessary for program evaluation, and to provide the coordination necessary for the demonstration program.

The Referral Center is staffed by Registered Nurses who are responsible for processing all beneficiary requests pertaining to second/third opinion consultation appointments.

L. Scheduling the Second Opinion Consultation Appointment

The beneficiary telephones the BCBSM Referral Center to request an appointment for a second opinion consultation relating to non-emergency (elective) surgery which was discussed and either recommended or not recommended by his/her first opinion physician.

The Referral Center:

- Determines the beneficiary's eligibility.
- Provides the beneficiary with names of surgical consultants appropriate to the beneficiary's condition. The names provided are chosen on a rotating basis from a roster of participating consultants located in the beneficiary's area of preference, and are of the same medical discipline as the beneficiary's first opinion physician.
- Schedules the appointment by telephoning the office of the consultant chosen by the beneficiary.
- Obtains medical information from the beneficiary's first opinion physician and makes the information available to the consultant chosen, if the beneficiary agrees. If the beneficiary does not wish the first opinion physician to be contacted, such a request will be respected.

APPENDIX 20: (Continued)

MSSOP Description Booklet

- Mails the necessary forms to the consultant prior to the scheduled appointment date.

M. Scheduling the Third Opinion Consultation Appointment

After receiving a second opinion, if the beneficiary wishes, he/she may request a third opinion consultation by telephoning the BCBSM Referral Center. The Referral Center provides the names of consultants in the same manner as in III L. Further, the Referral Center makes the necessary forms and information available to the third opinion consultant.

N. Cost of the Consultation

Consultants under this program agree to accept as payment in full their charges, up to a maximum of $50, and agree not to require additional payment from the beneficiary.

O. Diagnostic Services

Results of diagnostic services performed by the first opinion physician can be utilized by the consultant except when the beneficiary requests confidentiality.

If the consultants need to perform additional diagnostic testing, this will be reimbursed by the program. Beneficiary deductibles and copayments will be waived if the tests are ordered from the consultant's office, from an independent lab or x-ray facility, or from the outpatient department of a hospital.

Should the tests be performed as a bed patient in a hospital, the hospital stay will be reimbursed following the normal Medicare inpatient hospital benefits. But the consultant's fee will be paid by the demonstration program.

P. Confidentiality

All information will be treated as confidential both by the BCBSM Referral Center and the consultant in accordance with the provisions of the Privacy Act of 1974 (Public Law 93-579) as prescribed in 5 U.S.C. 522 a(e)4.

Q. Other

Beneficiaries will be informed that, should they be requested to pay themselves for any expenses relating to services provided in connection with this program, they advise the Referral Center. The Referral Center will review the circumstances and have the beneficiary reimbursed for out-of-pocket expenses which should have been paid by the program.

APPENDIX 20: (Continued)

MSSOP Description Booklet

IV. Further Information

Consultations and general information on the Medicare Surgical Second Opinion Program can be obtained by calling the Referral Center at 225-0112 between 8:30 a.m. and 5:00 p.m., Monday through Friday, or by writing to:

Referral Center, J713
Blue Cross and Blue Shield of Michigan
600 Lafayette East
Detroit, Michigan 48226

In addition, the telephone numbers listed below may be contacted directly by physicians in general; other professionals and providers of health care; and leaders (or their representatives) of organizations, agencies or groups requesting a more comprehensive or detailed explanation of the Program's policies and provisions.

Alex Caragay **225-0234**

Ann Simpson **225-9652**

APPENDIX 21:

MSSOP Consultant's Manual

CONSULTANT'S MANUAL

Terms and Conditions

Blue Cross
Blue Shield
of Michigan

Referral Center, J713
Blue Cross and Blue Shield of Michigan

Health Care Financing Administration
U.S. Department of Health,
Education and Welfare

APPENDIX 21: (Continued)

MSSOP Consultant's Manual

CONSULTANT'S MANUAL
MEDICARE SURGICAL SECOND OPINION PROGRAM

TABLE OF CONTENTS

		PAGE
1.	Introduction	1
2.	Nature and Purpose of the Demonstration Program	1
3.	Qualifications of Program Consultants	2
4.	Recruitment of Consultants	2
5.	The Participation Agreement	2
6.	Responsibilities of Program Consultants	2
7.	Consultation Fee	4
8.	Procedure Codes	4
9.	Submission of Claims	5
10.	Submission of Consultant's Report	6
11.	BCBSM Professional Liability Coverage Responsibility	6
12.	For Further Information	6

APPENDIX 21: (Continued)

MSSOP Consultant's Manual

MEDICARE SURGICAL SECOND OPINION PROGRAM TERMS AND CONDITIONS

1. Introduction

1.1 This manual contains the terms and conditions for those surgeons who agree to serve as consultants to the Medicare Surgical Second Opinion Program when providing second/third opinion consultations to Medicare beneficiaries whose consultation appointments are arranged through the Blue Cross and Blue Shield of Michigan (BCBSM) Referral Center.

1.2 It is not intended to be followed for Medicare beneficiaries whose second opinion consultation appointments are directly arranged by them or their physicians without the use of the BCBSM Referral Center, since these appointments are payable under Medicare as a general benefit.

2. Nature and Purpose of the Demonstration Program

2.1 The Medicare Surgical Second Opinion Program is a demonstration program conducted by BCBSM under the auspices of the Health Care Financing Administration (HCFA) of the U.S. Department of Health, Education and Welfare. It covers Medicare beneficiaries who reside in the Michigan counties of Wayne, Oakland or Macomb and who request and arrange their second/third opinion consultations through the BCBSM Referral Center.

2.2 The U.S. Department of Health, Education and Welfare (HEW) is currently developing an approach to encourage the American Public, and especially its own beneficiaries, to seek second opinions prior to elective surgery. Further details about the mechanics of the national program are still being worked out by the U.S. Department of Health, Education and Welfare. BCBSM will try to keep you informed of new developments as they evolve.

2.3 The primary difference between the Medicare Surgical Second Opinion Program being administered by BCBSM and the national effort being designed by HEW, from a standpoint of reimbursement, is that beneficiaries covered under the demonstration program have no coinsurance or deductible liability for the consultant's fee or any radiology or laboratory services ordered by the consultant.

2.4 The results of the Medicare Surgical Second Opinion Program will be used by HEW to determine whether second

APPENDIX 21: (Continued)

MSSOP Consultant's Manual

opinion coverage improves the quality of health care while helping to contain its costs.

3. Qualifications of Program Consultants

Consultants in this demonstration program are limited to those who have professional liability coverage; practice in the experimental area of Wayne, Oakland, and Macomb counties; and are:

3.1 Doctors of Medicine (M.D.) who are Board Certified surgical specialists.

3.2 Doctors of Osteopathic Medicine (D.O.) who are Certified surgical specialists.

3.3 Doctors of Dental Surgery (D.D.S.) who are Board Certified Oral Surgeons.

3.4 Doctors of Podiatric Medicine (D.P.M.) who are either Board Certified by the A.B.P.S. or are Fellows of the A.C.F.S.

4. Recruitment of Consultants

4.1 Recruitment of consultants is accomplished through letters of invitation to doctors who meet the qualifications of the program in specialties appropriate to the needs of the program, or through a local specialty society which has agreed to assist in the recruitment of consultants.

5. The Participation Agreement

5.1 Surgeons who wish to serve as program consultants must sign a BCBSM special Registration and Participation Agreement with Addendum, and must agree to the conditions and terms of participation as stated under Responsibilities of Program Consultants, which follows.

6. Responsibilities of Program Consultants

Program consultants must agree to the following:

6.1 They and their associates shall not render the surgical service to beneficiaries for whom they have provided a second/third opinion.

6.2 They shall personally examine the beneficiary, render the second/third opinion, discuss the recommendation with the beneficiary and complete the Consultant's Report for the BCBSM Referral Center.

6.3 They shall refer the beneficiary back to the care of the original physician. However, if the beneficiary should specifically

APPENDIX 21: (Continued)

MSSOP Consultant's Manual

request it, referral may be made to another physician, barring conflict of interest*. If referral to another physician is made, the consultant must document the referral on the reverse side of the Referral Center's copy of the Consultant's Report, i.e. the Consultant must indicate the beneficiary requested the referral and must give the name, address and specialty of the physician.

6.4 They shall accept the consultation fee set forth by the program as payment in full for their professional services with no additional charges to the beneficiary.

6.5 They shall schedule the consultation appointment so as not to delay a beneficiary's scheduled hospitalization.

6.6 They must inform the Referral Center by telephone if they cannot see the beneficiary on the scheduled appointment date, or if the beneficiary fails to keep the appointment as scheduled.

6.7 They must not contact the beneficiary's First Opinion Physician (F.O.P.) to obtain information or to discuss the outcome of the consultation if the beneficiary specifically requests that the F.O.P. not be informed of the second/third opinion consultation. Should the consultant find it advisable to confer with the beneficiary's F.O.P., the beneficiary's consent must first be obtained and this consent should be documented on the reverse side of the Referral Center's copy of the Consultant's Report.

6.8 They shall rely on existing laboratory and x-ray reports, ordering diagnostic services only when absolutely necessary.

6.9 They, to the extent possible, should perform any diagnostic services at their offices or use the services of an independent lab/x-ray facility certified by Medicare, to ensure that the beneficiary's deductible and copayment will not be applied, requiring out-of-pocket expenses.

6.10 They will complete the Consultant's Report and claims related to this program as described in this manual and any subsequent instructions issued for clarification.

6.11 They will advise a beneficiary, who must be hospitalized for testing in order to provide a second/third opinion, that only the consultation is paid by the second opinion program and that the hospitalization is subject to normal Medicare benefits and limitations for inpatient stays.

*For this program, conflict of interest is defined as referral of patients to physicians in a group, association, partnership, or professional corporation in which the consultant has any financial or family interest.

APPENDIX 21: (Continued)

MSSOP Consultant's Manual

6.12 They will advise the beneficiary if any needed tests are not payable by Medicare and, hence, not payable by this program so that the beneficiary will understand that the tests are to be paid by the beneficiary.

6.13 They will advise the beneficiaries making their own appointments (self arranged appointments) that they can have the consultation covered by the demonstration program if they contact the BCBSM Referral Center. Further, the consultants must agree that they will not submit their claims until they have received, completed, and mailed the Consultant's Report to the BCBSM Referral Center for patients who then call the Referral Center for coverage of this appointment.

6.14 They must agree to keep all information relating to the program confidential in accordance with the provisions of the Privacy Act of 1974 (Public Law 93-579) as prescribed in 5 U.S.C. a(e)4.

6.15 They are required to give 30 days notice to BCBSM if they wish to resign from participation as a program consultant. They are required to complete all scheduled appointments for the Medicare Surgical Second Opinion Program before the effective date of resignation.

7. Consultation Fee

7.1 The consultant will be paid based on charges but not to exceed $50 per consultation.

7.2 The fee will represent payment in full for the consultation appointment and no additional charge will be made to the beneficiary.

7.3 The beneficiary has been informed that he/she should not pay for any additional charges, with the exception of charges billed for diagnostic services rendered but not covered under Medicare Part B. The beneficiary has also been informed that charges for the consultation and related diagnostic services will be paid by the program if the second/third opinion consultation appointment was arranged through the BCBSM Referral Center.

8. Procedure Codes

8.1 The following Procedure Codes are to be used under this program when reporting consultation services:

- Procedure Code 0018 — To designate second opinion consultations relating to surgery.

APPENDIX 21: (Continued)

MSSOP Consultant's Manual

- Procedure Code 0019 — To designate third opinion consultations relating to surgery.

8.2 Diagnostic services performed in conjunction with the consultation are to be reported with the normal procedure codes with their nomenclature as indicated in the BCBSM Physician's Manual, Section 3.

9. Submission of Claims

9.1 For consultant's services rendered under this program, the consultant must use the special Request for Medicare Payment Form 1490 (printed on yellow stock) which has been partially completed and forwarded by the BCBSM Referral Center prior to the scheduled appointment date. The completed Form 1490 should then be submitted, in the reply envelope provided, to the Referral Center at BCBSM along with the completed Consultant's Report.

9.2 For requesting payment for diagnostic services performed under this program, a separate partially completed special Request for Medicare Payment Form 1490 (printed on yellow stock with blue ink), which will be sent by the Referral Center, must be used.

9.3 For tests performed in the Consultant's office:

- Complete yellow 1490 claim form for the testing and forward it with the consultation claim form and the Consultant's Report to the Referral Center in the preaddressed envelope provided.
- No patient copayment or deductible is to be charged.

9.4 For tests ordered from an independent lab/x-ray facility:

- Be sure the "instruction card" is attached to the partially completed 1490 claim form, printed on yellow stock with blue ink. This will advise the facility of the correct procedures for billing and reporting the services.
- Send the special 1490 claim form with the "instruction card" to the facility so that it will use the claim form rather than billing in its normal manner.

9.5 For tests ordered from a hospital laboratory or radiology department:

Attach the card "Instructions to Hospital" to the order for the tests so that the claim can be separated for special handling and the patient's deductible or copayment waived.

APPENDIX 21: (Continued)

MSSOP Consultant's Manual

9.6 Additional special yellow 1490 claim forms for the program can be obtained from the Referral Center.

10. Submission of Consultant's Report

The completed Consultant's Report must be mailed promptly to the BCBSM Referral Center, and to avoid any delay in payment, should be sent with the completed special 1490 claim form for services performed in the Consultant's office and laboratory.

11. BCBSM Professional Liability Coverage Responsibility

11.1 Blue Cross and Blue Shield of Michigan has had discussions with professional liability carriers as well as with the Bureau of Insurance of the State of Michigan. The Bureau advises BCBSM that all current professional liability contracts include coverage for misadventures in consultations, inclusive of those occurring in surgical second opinion programs.

11.2 BCBSM is also advised that the current premiums include such liability; therefore, no carrier would have occasion to increase the premium for participating consultants.

11.3 For physicians who agree to participate as consultants in the BCBSM Medicare Surgical Second Opinion Program, Blue Cross and Blue Shield of Michigan will commit to payment of the surcharge differential and/or replacement premium differential for comparable coverage, for a period of up to three policy years from the date of such action, if such surcharge and/or cancellation is occasioned by a professional liability claim involving a consultation in the BCBSM Medicare Surgical Second Opinion Program conducted through its second opinion Referral Center.

11.4 BCBSM will not commit to assumption of any liability for participation of consultants who do not have professional liability coverage.

12. For Further Information

The Referral Center Staff is trained to answer your questions as well as to assist beneficiaries. If any difficulties should arise in connection with the Program, or if additional information is needed, please telephone the Referral Center at 225-0112 between 8:30 a.m. and 5:00 p.m., Monday through Friday, or write to:

Referral Center, J713
Blue Cross and Blue Shield of Michigan
600 Lafayette East
Detroit, Michigan 48226

APPENDIX 22:

MSSOP Referral Center Intake Form, HCFA-36T

HCFA-36T

MEDICARE SURGICAL SECOND OPINION PROGRAM (MSSOP)
REFERRAL CENTER INTAKE

(Please Print)

PART A: ELIGIBILITY DETERMINATION *(Complete during telephone interview, except coding)*

BENEFICIARY'S CONTACT WITH REF. CENTER: DATE	TIME REC'D	COMPLETED	TOTAL MINUTES	ANALYST

01. HIB NUMBER	02. OPINION	03. MSSOP NUMBER
	1 SECOND 2 THIRD	

BENEFICIARY'S NAME (Last) (First) (Middle Initial)

BENEFICIARY'S ADDRESS (Number) (Street) (City) APARTMENT NUMBER

04. County	05. State	06. Zip Code

DIAGNOSIS OR NATURE OF COMPLAINT	07. DX. CODE

SURGICAL PROCEDURE DISCUSSED (Description)	08. PROC. CODE

NOTE: If third opinion is requested, proceed to Part C

09. WAS SURGERY RECOMMENDED BY PHYSICIAN? 1 YES 2 NO

10. IS THE FIRST OPINION PHYSICIAN A SURGICAL SPECIALIST? 1 YES 2 NO 9 UNKNOWN

11. DATE ON WHICH ELECTIVE SURGERY WAS DISCUSSED WITH FIRST OPINION PHYSICIAN (F.O.P.) MO. DAY YEAR

12. IF F.O.P. RECOMMENDED SURGERY, HAS IT BEEN SCHEDULED? 1 YES 2 NO

13. SITE OF SURGERY 1 HOSPITAL INPATIENT 3 HOSPITAL OUTPATIENT 3 DOCTOR'S OFFICE 4 OTHER

14. DATE OF SURGERY

NAME AND ADDRESS OF SITE OF SURGERY:

15. IS BENEFICIARY ELIGIBLE FOR CONSULTATION? 1 YES 2 NO

16. IF NOT ELIGIBLE, CHECK REASON:

1 PROCEDURE NOT COVERED, EMERGENCY
2 PROCEDURE NOT COVERED, CONTRACT EXCLUSION
3 PROCEDURE NOT COVERED, PROJECT EXCLUSION
4 MEDICARE CONTRACT NOT CURRENT
5 BENEFICIARY RESIDES OUTSIDE STUDY AREA
6 OVER 120 DAYS
7 CLAIM ALREADY PROCESSED

PART B: FOR ELIGIBLE BENEFICIARIES ONLY *(Complete during telephone interview, except coding)*

17. DATE OF BIRTH MO. DAY YEAR	18. IS BENEFICIARY RETIRED? 1 YES 2 NO	OCCUPATION (Specify)	19. OCCUPATION CODE	20. SEX 1 M 2 F

21. MARITAL STATUS 1 SINGLE 2 MARRIED 3 WIDOWED 4 DIVORCED 5 SEPARATED

NAME OF FIRST OPINION PHYSICIAN (Last, First, Middle Initial)

22. TYPE OF DOCTOR, FIRST OPINION PHYSICIAN 1 M.D. 2 D.O. 3 O.P.M. 4 ORAL SURG.

OFFICE ADDRESS (Number, Street, City, County, State, Zip Code) TELEPHONE NUMBER

23. DOES BENEFICIARY WISH FIRST OPINION PHYSICAN TO BE INFORMED OF THE CONSULTATION REQUEST? IF NO, GIVE REASON 1 YES 2 NO

24. DOES BENEFICIARY WISH FIRST OPINION PHYSICIAN TO BE INFORMED OF CONSULTATION OUTCOME? IF NO, GIVE REASON 1 YES 2 NO

25. HOW DID THE BENEFICIARY HEAR ABOUT THE PROGRAM?

1 SENIOR CITIZEN GROUPS 2 RADIO 3 NEWSPAPER 4 PHYSICIAN 5 OTHER (Specify)

26. DOES BENEFICIARY HAVE OTHER HEALTH INSURANCE? 1 YES 2 NO	27. IF YES, CHECK APPROPRIATE BOXES
	1 MEDICAID 2 BLUE CROSS/BLUE SHIELD 3 COMMERCIAL 4 OTHER

CONVENIENT DAYS AND TIMES TO SCHEDULE APPOINTMENTS:

NOTE: The authority for collecting the above information is contained in section 402(a) of the 1967 amendments to the Social Security act, as amended by section 222(b) of the 1972 amendments to the Social Security Act, P.L. 92—603. Disclosure of such information is voluntary. The information collected on this form will be used to conduct referrals and to evaluate the impact of the program. If individuals do not provide the information, they may not be able to obtain a consulation with waiver of copayment and deductible requirements.

2981-9 MAR 78

(OVER)

APPENDIX 23:

Cover Letter for Consultant's Package

Dear Doctor:

Thank you for scheduling a Medicare Surgical Second Opinion consultation appointment for:

Name of Patient -

Date and Time -

Place -

Attached for your attention are the necessary program materials:

1. Blank Consultant's Report - To be completed and promptly returned in the reply envelope to the Referral Center, along with the completed special Form 1490 (Request for Medicare Payment) which will be used to submit your claim for the second/third opinion consultation. Please detach and retain your copy of the Consultant's Report.

2. Partially Completed Special Form 1490 (Request for Medicare Payment) - To be used only for professional services rendered in providing the second/third opinion consultation. Please complete the pertinent information, retain one copy and return the form in the reply envelope to the Referral Center along with the completed Item 1.

3. Additional Partially Completed Special Form 1490 (Request for Medicare Payment) - To be completed if ancillary services are orderd as part of the second/third opinion consultation. If the ancillary services are performed at your office, please complete the special Form 1490 and mail it to the Referral Center along with Items 1 and 2. If the ancillary services are to be performed at an independent lab or x-ray facility, please forward this additional partially completed special Form 1490, along with the attached instructions, to the facility. Additional partially completed 1490s may be obtained by calling the Referral Center at 225-0112.

   NOTE: If the ancillary services are to be performed at a hospital outpatient department, do not send the partially completed special Form 1490 to the hospital. Rather, forward the attached instructions to the hospital along with your request for lab and/or x-ray services.

APPENDIX 23: (Continued)

Cover Letter for Consultant's Package

4. A Completed First Opinion Physician Report Form - To be retained in your file. Other medical information pertinent to the consultation may be forwarded directly to you by the First Opinion Physician or hand delivered by the patient.

5. A Reply Envelope - To be used for returning completed Items 1, 2 and 3 to the Referral Center.

Please do not send the completed forms directly to the BCBSM Claims Receipt area. These forms must be routed through the Referral Center to avoid unnecessary delay in processing.

If you have any questions regarding the above materials, please call the Referral Center at 225-0112.

Sincerely,

Louis F. Hayes, M.D.
Vice President
Professional Affairs Group

LFH:mao

Enclosures

APPENDIX 24:
MSSOP Consultant's Report, HCFA-38T

Please print or type. Retain third copy. Mail first and second copies to address below

HCFA-38T

Blue Cross Blue Shield of Michigan

REFERRAL CENTER #J713
600 LAFAYETTE EAST, DETROIT, MICHIGAN 48226

MEDICARE SURGICAL SECOND OPINION PROGRAM (MSSOP)

CONSULTANT'S REPORT

01 H.I.B. NUMBER	02 OPINION [1] SECOND [2] THIRD	03 MSSOP NO	BENEFICIARY'S NAME (LAST) (FIRST) (MIDDLE INIT.)

BENEFICIARY'S ADDRESS (NUMBER) (STREET) (CITY) APARTMENT NO

04 (COUNTY) 05 (STATE) 06 (ZIP CODE)

CONSULTANT'S DIAGNOSIS (STANDARD NOMENCLATURE) 07. DX CODE

08 NEED FOR SURGERY

CONFIRMED [1]

NOT CONFIRMED [2]

SURGICAL PROCEDURE RECOMMENDED BY CONSULTANT, IF SURGERY CONFIRMED (STANDARD NOMENCLATURE) 09. PROC. CODE

10 RECOMMENDED LOCATION FOR SURGERY
[1] HOSPITAL INPATIENT [2] HOSPITAL OUTPATIENT [3] OFFICE [4] OTHER

11 IS SURGICAL PROCEDURE RECOMMENDED THE SAME AS RECOMMENDATION OF FIRST OPINION PHYSICIAN?
[1] YES [2] NO [3] UNKNOWN

12 SURGERY NOT RECOMMENDED BECAUSE: (CHECK ALL PERTINENT BLOCKS)
[1] NO TREATMENT NECESSARY [2] NO PATHOLOGY FOUND

13 TRIAL OF MEDICAL TREATMENT INDICATED AS FOLLOWS
[3.1] MEDICATION [3.2] PHYSICAL THERAPY: [3.3] DIET THERAPY [3.4] OTHER THERAPY (SPECIFY:)
[4] COMPLICATING CONCURRENT CONDITION(S) [5] RE-EVALUATION INDICATED
[6] FURTHER DIAGNOSTIC STUDIES (SPECIFY) [7] OTHER (SPECIFY)

CONSULTANT'S REMARKS FOR THE RECOMMENDED NEXT THERAPEUTIC STEP

LIST LABORATORY X-RAY OR OTHER DIAGNOSTIC TESTS ORDERED WHEN APPLICABLE)

DESCRIPTION OF TEST	RESULT OF TEST	PROCEDURE CODES
		13.
		14.
		15.
		16.
		17.
		18.

NOTE: IF MORE THAN SIX PROCEDURES PLEASE LIST ON A SEPARATE SHEET 19 [ ]

LOCATION AT WHICH LABORATORY X-RAY, OR OTHER DIAGNOSTIC TESTS WERE PERFORMED

NAME	ADDRESS	CHECK BELOW
		20. [1] DR. OFFICE [2] HOSPITAL [3] INDEPENDENT
		21. [1] DR. OFFICE [2] HOSPITAL [3] INDEPENDENT
		22. [1] DR. OFFICE [2] HOSPITAL [3] INDEPENDENT

23 BY OBSERVATION, PLEASE STATE PATIENT'S RACE
[1] WHITE, NOT OF HISPANIC ORIGIN
[2] BLACK, NOT OF HISPANIC ORIGIN
[3] HISPANIC
[4] AMERICAN INDIAN OR ALASKAN NATIVE
[5] ASIAN OR PACIFIC ISLANDER

24 REASON FOR ORDERING LABORATORY, X-RAY OR OTHER DIAGNOSTIC TESTS (CHECK APPROPRIATE BOX)
[1] DID NOT RECEIVE F.O.P. REPORT
[2] EXISTING REPORTS INCONCLUSIVE
[3] NEEDED UPDATED RESULTS
[4] NEEDED TO VERIFY EXISTING RESULTS
[5] OTHER

SIGNATURE OF CONSULTANT 25 DATE OF APPOINTMENT

NOTE: The authority for collecting the above information is contained in section 402(a) of the 1967 amendments to the Social Security Act, as amended by section 222(b) of the 1972 amendments to the Social Security Act, P.L. 92-603. Disclosure of such information is voluntary. The information collected on this form will be used to evaluate the impact of the program. If individuals do not provide the information, their agreement as a participating consultant may be terminated with 30 days notice.

2980-1 MAR 78

REFERRAL CENTER COPY

APPENDIX 25:

Request for Medicare Payment, HCFA-1490(2)

U.S. GPO:1978-0-261-077/18

REQUEST FOR MEDICARE PAYMENT

MEDICAL INSURANCE BENEFITS—SOCIAL SECURITY ACT (See Instructions on Back — **Type or Print Information**) Form Approved OMB No. 0966-R 0012

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (20 CFR 422.510).

NOTICE—Anyone who misrepresents or falsifies essential information requested by this form may upon conviction be subject to fine and imprisonment under Federal Law.

PART I—PATIENT TO FILL IN ITEMS 1 THROUGH 6 ONLY

When completed, send this form to:
Blue Cross and Blue Shield of Michigan
Referral and Information Center J713
600 Lafayette East
Detroit, Michigan 48226

Copy from YOUR OWN HEALTH INSURANCE CARD *(See example on back)*

1 Name of patient (First name, Middle initial, Last name)

2 Health insurance claim number *(Include all letters)* ☐ Male ☐ Female

3 Patient's complete mailing address (including Apt. no.) City, State, ZIP Code | Telephone Number

4 Describe the illness or injury for which you received treatment *(Always fill in this item if your doctor does not complete Part II below)* | Was your illness or injury connected with your employment? ☐ Yes ☐ No

5 If any of your medical expenses will be or could be paid by another insurance organization or government agency, show below
Name and address of organization or agency | Policy or Identification Number

Note: If you **Do Not** want information about this Medicare claim released to the above upon its request, check (X) the following block ☐

6 I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment below.

SIGN HERE — Signature of patient *(See instructions on reverse where patient is unable to sign)* | Date signed

PART II—PHYSICIAN OR SUPPLIER TO FILL IN 7 THROUGH 14 ONLY

7 A. Date of each service	B. Place of service (*See Codes below*)	C. Fully describe surgical or medical procedures and other services or supplies furnished for each date given (If lab service, indicate if automated) — Procedure Code	D. Nature of illness or injury requiring services or supplies	E. Charges (If related to unusual circumstances explain in 7C)	Leave Blank
				$	

8 Name and address of physician or supplier *(Number and street, city, State, ZIP code)*

Telephone No. | 9 Total charges $

Physician or supplier code | 10 Amount paid $

11 Any unpaid balance due $

12 Assignment of patient's bill
☐ I accept assignment *(See reverse)* ☐ I do not accept assignment

13 Name and address of person or facility where services were furnished *(Complete if outside your own office or patient's residence)*.

14 Signature of physician or supplier (I certify that the statements under Physicians' Notes on the reverse apply to this bill and are made a part hereof.) | Date Signed

O—Doctor's Office L—Independent Laboratory H—Patient's Home *(If portable X-ray service, identify by O or L)* I—Inpatient Hospital SNF—Skilled Nursing Facility OP—Outpatient Hospital E—Other Locations NH—Nursing Home

FORM HCFA-1490(2) 1-73 (FORMERLY SSA-1490-2) Department of Health, Education and Welfare—Health Care Financing Administration

APPENDIX 25: (Continued)

Request for Medicare Payment, HCFA-1490(2)

HOW TO FILL OUT YOUR MEDICARE FORM

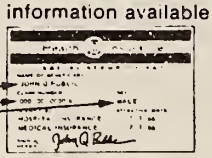
There are two ways that Medicare can help pay your doctor bills

One way is for Medicare to pay your doctor.—If you and your doctor agree, Medicare will pay the doctor directly. This is the assignment method. You do not submit any claim; the doctor does. All you do is fill out Part I of this form and leave it with your doctor. Under this method the doctor agrees to accept the charge determination of the Medicare carrier as the full charge for covered services; you are responsible for the deductible, coinsurance, and non-covered services. Please read Your Medicare Handbook to help you understand about the deductible and coinsurance.

The other way is for Medicare to pay you.—Medicare can also pay you directly—before or after you have paid your doctor. If you submit the claim yourself, fill out Part I and ask your doctor to fill out Part II. If you have an itemized bill from the doctor, you may submit it rather than have the doctor complete Part II. (This form, with Part I completed by you, may be used to send in several itemized bills from different doctors and suppliers.) Bills should show who furnished the services, **the patient's name and number,** dates of services, where the services were furnished, a description of the services, and charges for each separate service. It is helpful if the diagnosis is also shown. Then mail itemized bills and this form to the address shown in the upper left-hand corner. If no address is shown there, use the address listed in Your Medicare Handbook—or get advice from any social security office.

Notice: It is important to keep a record of your claim in case you ever want to inquire about it. Before you send it in, write down the date you mailed it, the services you received, the date and charge for each, and the name of the doctor or supplier who performed the services. Have this information available when you inquire about a claim.

SOME THINGS TO NOTE IN FILLING OUT PART I
(Your doctor will fill out Part II.)



1 & **2** Copy the name and number and indicate your sex exactly as shown on your health insurance card. Include the letters at the end of the number.

3 Enter your mailing address and telephone number, if any.

4 Describe you illness or injury.
Be sure to check one of the two boxes.

5 If you have other health insurance or expect a welfare agency to pay part of the expenses, complete item 5.

6 Be sure to sign your name. If you cannot write your name, sign by mark (X), and have the signature witnessed. The witness's signature and address must also be shown in item 6.
If you are filing the claim for a Medicare beneficiary, in item 6 enter the patient's name and write "By," sign your name and enter your address in this space, show your relationship to the patient, and explain why the patient cannot sign. (If the patient has died, the survivor should contact any social security office for information on what to do.)

COLLECTION AND USE OF MEDICARE INFORMATION

We are authorized by the Health Care Financing Administration to ask you for information needed in the administration of the Medicare program. Authority to collect information is in section 205(a), 1872 and 1875 of the Social Security Act, as amended.

The information we obtain to complete your Medicare claim is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by Medicare and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, and other organizations as necessary to administer the Medicare program. For example, it may be necessary to disclose information about the Medicare benefits you have used to a hospital or doctor.

With one exception, which is discussed below, there are no penalties under social security law for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of the claim. Failure to furnish any other information, such as name or claim number, would delay payment of the claim.

It is mandatory that you tell us if you are being treated for a work related injury so we can determine whether workmen's compensation will pay for the treatment. Section 1877(a)(3) of the Social Security Act provides criminal penalties for withholding this information.

IMPORTANT NOTES FOR PHYSICIANS AND SUPPLIERS

Item 12: In assigned cases, the physician agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the carrier, if this is less than the charge submitted. If the physician or supplier does not want Part II information released to the organization named in item 5, the physician or supplier should write "No further release" in item 7C following the description of services.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally rendered by me or were rendered incident to my professional service by my employee under immediate personal supervision, except as otherwise expressly permitted by Medicare regulations.

For services to be considered as 'incident to' a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his employee, 2) there was a covered physician's service rendered of which the other services are an integral, although incidental part, 3) they must be of kinds commonly furnished in physicians offices, and 4) the services of nonphysicians must be included on the physicians' bills.

Notice: Anyone who misrepresents or falsifies essential information to receive payment from federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable federal laws.

APPENDIX 26:

Instructions for Submitting Ancillary Services Claims, Excluding Those Performed at the Consultant's Office

Blue Cross Blue Shield of Michigan

Instructions for Submitting Ancillary Service Claims Other Than Those Performed at the Consultant's Office

1. Ancillary Services performed at an independent laboratory or X-ray facility

a. The consultant will forward to the facility the partially completed Special yellow Form 1490 along with these instructions.

b. The independent facility will:

- Fill out the partially completed Special yellow Form 1490. No Automated Input will be accepted.
- Mail the completed Special Form 1490 *directly* to the BCBSM Referral Center Address given in Item 3.
- Accept Assignment, and agree not to bill the beneficiary for additional charges. The program covers all copayments and deductibles.

NOTE: Additional Special Form 1490s are available by calling 225-0112.

2. Ancillary Services performed at a hospital Outpatient Department

a. The consultant will forward to the hospital his/her request for services, along with these instructions.

b. The hospital Outpatient Department will:

- Complete Form 1483, indicating "Second Opinion Program" in the Remarks Section. No Automated Input will be accepted.
- Mail the completed Form 1483 *directly* to the BCBSM Referral Center Address given in Item 3.
- Not bill the beneficiary for copayments or deductibles. These will be covered by the program.

3. Address for the BCBSM Referral Center

Referral Center, J713
Blue Cross and Blue Shield of Michigan
600 Lafayette East
Detroit, Michigan 48226

6520-1 JUL 78

APPENDIX 27:
First Opinion Physician's Report, HCFA-37T

Retain third copy. Mail completed first and second copies to address below

Blue Cross Blue Shield of Michigan

REFERRAL CENTER #J713
600 LAFAYETTE EAST, DETROIT, MICHIGAN 48226

HCFA - 37T

MEDICARE SURGICAL SECOND OPINION PROGRAM (MSSOP)

FIRST OPINION PHYSICIAN'S REPORT

TO BE COMPLETED BY REFERRAL CENTER
(PLEASE PRINT OR TYPE)

01 HIB NUMBER	02 MSSOP NUMBER	
BENEFICIARY'S NAME (LAST) (FIRST) (MIDDLE INITIAL)		
BENEFICIARY'S ADDRESS (NUMBER (STREET) (CITY)		APARTMENT NUMBER
03 (COUNTY)	04 (STATE)	05 (ZIP CODE)

TO BE COMPLETED BY FIRST OPINION PHYSICIAN
(PLEASE PRINT OR TYPE)

DIAGNOSIS (STANDARD NOMENCLATURE) PRIMARY		06 DX CODE
07 WAS SURGERY RECOMMENDED [1] YES [2] NO	IF YES, TYPE OF SURGERY RECOMMENDED (STANDARD NOMENCLATURE) PRINCIPAL	08 PROC CODE
IF NO, TYPE OF SURGERY DISCUSSED (STANDARD NOMENCLATURE) PRINCIPAL		09 PROC CODE

10 RECOMMENDED SITE OF SURGERY
[1] HOSPITAL INPATIENT [2] HOSPITAL OUTPATIENT [3] DOCTOR'S OFFICE [4] OTHER

PERTINENT HISTORY SYMPTOMS AND PHYSICAL FINDINGS

LIST OF LABORATORY, X-RAY OR OTHER DIAGNOSTIC TESTS ORDERED

DESCRIPTION OF TEST	RESULT OF TEST	PROC. CODE
		11.
		12.
		13.
		14.
		15.
		16.
NOTE: IF MORE THAN SIX TESTS, PLEASE LIST ON A SEPARATE SHEET		17. [ ]

NAME OF FIRST OPINION PHYSICIAN		OFFICE ADDRESS	
TELEPHONE NUMBER	18 TYPE OF PRACTICE [1] SOLO [2] GROUP	19 FORM COMPLETED BY [1] DOCTOR'S OFFICE MAILED [2] DOCTOR'S OFFICE TELEPHONED [3] REFERRAL CENTER W/ BENEFICIARY'S INPUT	DATE

NOTE: The authority for collecting the above information is contained in section 402(a) of the 1967 amendments to the Social Security Act, as amended by section 222(c) of the 1972 amendments to the Social Security Act, P.L. 92—603. Disclosure of such information is voluntary.

The information on this form will be used to aid consultants in evaluating the beneficiary's condition and to evaluate the impact of the program. If individuals do not provide the information, consultant opinions will lack background on the beneficiary which only the first opinion physician/surgeon can provide and evaluation will be impaired. However, nondisclosure will not affect the first opinion physician/surgeon.

2982-7 MAR 78

REFERRAL CENTER COPY

APPENDIX 28:

MSSOP Confirmation of Appointment Card

MEDICARE SURGICAL SECOND OPINION PROGRAM
CONFIRMATION OF APPOINTMENT

This is to confirm the consultation appointment for:

_____

The appointment is scheduled for:
Date _____ Time _____
Consultant's Name
Office Address _____

_____

If it is not possible to keep this appointment for any reason, please notify the Referral Center as soon as possible at 225-0112.

Further, please inform the Referral Center if you are charged directly for services rendered as part of your second/third opinion consultation.

5517-8 Mar 78

Blue Cross
Blue Shield
of Michigan

Referral Center #J713
600 Lafayette East
Detroit, Michigan 48226

RETURN POSTAGE GUARANTEED

APPENDIX 29:

List of Railroad Retiree HIC Numbers

The basic railroad retiree HIC numbers can either be 6 digit or 9 digit numbers, however they always have letter prefixes. Below are listed the potentially valid Railroad Retirement HIC numbers.

A-000000 or A-000-00-0000

MA-000000 or MA-000-00-0000

WA-000000 or WA-000-00-0000

WD-000000 or WD-000-00-0000

CA-000000 or CA-000-00-0000

WCA-000000 or WCA-000-00-0000

WCD-000000 or WCD-000-00-0000

PA-000000 or PA-000-00-0000

PD-000000 or PD-000-00-0000

H-000000 or H-000-00-0000

MH-000000

WH-000000

WCH-000000

PH-000000

JA-000000

APPENDIX 30:

List of Valid Medicare HIC Numbers

000-00-0000-A

000-00-0000-B, B1, B2, B3, B4, B5, B6, B7, B8, B9

000-00-0000-C, C1, C2, C3, C4, C5, C6, C7, C8, C9, CA, CB, CC, etc.

000-00-0000-D, D1, D2, D3, D4, D5, D6, D7, D8, D9, DA

000-00-0000-E, E1, E2, E3, E4, E5, E6, E7, E8, E9

000-00-0000-F, F1, F2, F3, F4, F5, F6, F7, F8

000-00-0000-J1, J2, J3, J4

000-00-0000-K1, K2, K3, K4, K5, K6, K7, K8

000-00-0000-W, W1, W2, W3, W6, W7

APPENDIX 31:
Request for Medicare Payment, SSA-1483

958

☆ U.S. GOVERNMENT PRINTING OFFICE— 1975—584—972/18

PROVIDER BILLING FOR MEDICAL AND OTHER HEALTH SERVICES

MEDICAL INSURANCE BENEFITS—SOCIAL SECURITY ACT

Form Approved
OMB No. 72-R0738

NOTICE: Anyone who misrepresents or falsifies essential information requested by this form may upon conviction be subject to fine and imprisonment under Federal law.

1. Patient's last name | First name | MI
2. Health insurance claim number
3. Patient's address (Street number, City, State, ZIP Code)
4. Date of birth
5. Sex ☐ M ☐ F
6. Provider name and address (City and State)
7. Provider number
8. Medical record number
9. Type of service
A. ☐ Inpatient C. ☐ Other (Specify)
B. ☐ Outpatient

If you have other health insurance or if your State Medical Assistance Agency will pay part of your medical expenses and you want information about this claim released to them upon their request, complete items 10 and 11.

10. Insuring organization and/or State agency name and address
11. Policy and/or medical assistance number

12. Patient's Certification, Authorization to Release Information, and Payment Request. I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf.

☐ Contained in provider's record | Signature (Patient or authorized representative) (Signature by mark must be witnessed) | Date

13. Nature of illness or injury ☐ Check here if illness or injury was connected with employment | Do not use this space

14. Surgical procedures

15. Statement of services	Covered Charges
A. Clinic visit ( )	
B. Emergency room ( )	
C. Laboratory	
D. Radiology	
E. Pharmacy	
F. Blood	
G. Ambulance	
H. Physical therapy	
I. Other (Specify)	
J. TOTAL	

16. Statement Covers Period — First service | Last service

17. Blood Information — A. Pints furnished | B. Pints replaced | Not Replaced: C. Pints | D. Charge per pint | E. Patient paid for deductible

18. Professional component (hospital inpatients) — A. Pathology | B. Radiology

19. Other professional component

20. Date benefits exhausted or HH plan terminated

21. Patient paid (Excluding 17E)

22. I certify that the required physician's certification is on file.

23. Date received

FOR INTERMEDIARY USE ONLY

24. Verified Patient Liability — A. Blood deductible | B. Cash deductible | C. Coinsurance

25. Payment Distribution — Provider | Patient

26. Date approved

Remarks:

FORM SSA-1483 1-73

Department of Health, Education, and Welfare
Social Security Administration

SIDE 1 **MEDICARE DEVELOPMENT CHECKLIST** SEE REVERSE SIDE

I RFP CHECKING ☐

__A. Provider's signature
__B. Beneficiary's signature
__C. Provider's code
__D. Illness/injury connected with employment

II DURABLE MEDICAL EQUIPMENT ☐

__A. Location of use (beneficiary's home, N.H., S.N.F.)
__B. Name/address of N.H./S.N.F.
__C. Admission/discharge date to N.H./S.N.F.
__D. Name/address of supplier
__E. Diagnosis requiring supply
__F. Duration of use
__G. Date of each rental/purchase
__H. Degree of disability
__I. Type of surgery requiring supply
__J. Itemized charges for each supply
__K. Itemized charges for each month's rent
__L. Statement of medical necessity for ___
_____

III CODING ☐

__A. Provider's code for _____
__B. Name & Address for _____
__C. Supplier's code for _____

IV D.C.'s ☐

__A. Condition–acute/chronic
__B. Diagnosis
__C. Level of subluxation
__D. Date of X–ray
__E. Certification for X–rays
__F. Date of first visit for condition
__G. Visit number for condition being treated

V PROSTHESIS ☐

__A. Glasses
  __1. Has patient had surgery?
  __2. Description glasses
  __3. Prescription for glasses

VI PSYCHIATRIC ☐

__A. Length of session
__B. Better diagnosis
__C. Type of therapy

VII PODIATRY ☐

__A. Reg. Physician's name for palliative care
__B. Type of X–ray

VIII CRD ☐

__A. Is dialysis for acute/emerg./maint.

IX OTHER ☐

__A. Resume's of prolonged attention
__B. Date of death
__C. Other _____
_____

DATE	INITIAL	REMARKS ANSWER EACH QUESTION INDIVIDUALLY, USE REVERSE SIDE IF NECESSARY

4430–5 AUG 76

* Reduction of Original

SIDE 2

I. GENERAL CLAIM DEVELOPMENT ☐

__A. Description of service
__B. Itemized charges for _____
__C. Date of service
__D. Location of services
__E. Diagnosis
  __1. Pap smear
  __2. X-rays
  __3. Emergency care
  __4. B-12 injections
  __5. EKG
__F. Name of material for injection

II. X-RAYS ☐

__A. Type of x-rays
__B. Location (inpatient, outpatient, office)
__C. Requesting doctor's name

III. PATHOLOGY ☐

__A. Name/address of lab.
__B. Profile
  __1. Number of tests
  __2. Automated, semi-automated, manual
__C. Name of test(s)
__D. Itemized charges for _____

IV. AMBULANCE ☐

__A. Point of origin
__B. Point of destination
__C. Miles travelled from origin to destination
__D. Why was ambulance service needed, could the patient travel by other means?
__E. What services are available at second hospital but not available at first hospital?

V. SURGERY ☐

__A. Type of surgery
__B. Exact description
__C. Size of lesion/laceration
__D. Area of lesion/laceration
__E. Length of laceration
__F. Duration of anesthesia
__G. Date/type of fracture care
__H. Location of service (inpt., oupt., off.
__I. Itemized charges for _____
__J. Surgeon's name
__K. Size of skin graft

VI. CONSULTATION ☐ I.H. CARE ☐

__A. Requesting doctor's name
__B. Location for consulation
__C. Admission date
__D. Discharge date
__E. Exact dates of in hospital care

VII. X-RAY THERAPY ☐ PHYSICAL THERAPY ☐

__A. Number of treatments
__B. Area of treatments
__C. Type of treatments
__D. Itemized charges for _____
__E. Statement of certification for services by _____

VIII. CORRESPONDENT ☐

__A. Doctor's signature or receipts
__B. Beneficiary's signature
__C. Mr. and Mrs. claim
  __1. HIB number
  __2. Name
  __3. Diagnosis
__D. Cancelled check/money order
__E. Operative notes
__F. Deceased Beneficiary Pay Beneficiary
__G. Conflicting assignment
__H. Resume' of prolonged attention
__I. Other _____

IX. OTHER ☐

_____
_____
_____
_____

DATE	INITIAL	REMARKS ANSWER EACH QUESTION INDIVIDUALLY. USE REVERSE SIDE IF NECESSARY

4430-8 AUG 76BP

* Reduction of Original

APPENDIX 33:

Medicare Part B Pricing Attachment

L	DATE OF SERVICE	LOC.	SER.	PROCEDURE CODE	ADJ.	CHARGE		AMOUNT TO BE PAID		DOCTOR'S CODE
1										
2										
3										
4										
5										

FORM NO. 4480 AUG 74

APPENDIX 34:

Monthly Intermediary Financial Report

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION

Form Approved.
Budget Bureau No. 72-R736

MONTHLY INTERMEDIARY FINANCIAL REPORT
HEALTH INSURANCE BENEFITS PROGRAM

MONTH ENDED

FROM: (Intermediary's name and address)

TO:
Social Security Administration
Bureau of Health Insurance
P.O. Box 1417
Baltimore, Maryland 21203

LETTER OF CREDIT NO.

MONTHLY LETTER OF CREDIT LIMIT

SECTION A – Purpose for Which Funds Were Drawn

TYPE OF FUNDS	FUNDS DRAWN THIS MONTH	TOTAL FUNDS DRAWN SINCE JULY 1ST	TOTAL FUNDS EXPENDED THIS MONTH	FUNDS ON HAND END OF MONTH
(a)	(b)	(c)	(d)	(e)
1. Hospital Insurance Benefits	10,000.00		10,000.00	
* 2. Supplementary Medical Ins. Benefits	1,000.00		1,000.00	
3. Regular Administrative Costs				
4. Nonrecurring Administrative Costs				
5. TOTALS	11,000.00		11,000.00	

FROM TO

6. Payment Vouchers Submitted During Month (List inclusive numbers)

SECTION B – Classification of Benefit Payments

SOURCE OF BENEFIT	BILLS PROCESSED			BILLS PAID	
	INCLUSIVE BATCH NOS.	NO. OF BILLS	AMOUNT	INCLUSIVE BATCH NOS.	AMOUNT
(a)	(b)	(c)	(d)	(e)	(f)
7. Hospital Insurance Trust Fund					
8. Supplementary Medical Ins. Trust Fund					
9. TOTAL – PART A INTERMEDIARIES					
10. Supplementary Medical Ins. Trust Fund					
11. GRAND TOTAL					

SECTION C – Retroactive Adjustments and Current Financing Payments (Part A Intermediaries Only)

SOURCE OF BENEFIT	RETROACTIVE ADJUSTMENTS		CURRENT FINANCING PAYMENTS
	CREDIT ADJUSTMENTS	SUPPLEMENTAL PAYMENTS	
(a)	(b)	(c)	(d)
12. Hospital Insurance Trust Fund			
13. Supplementary Medical Ins. Trust Fund			
14. TOTAL – PART A INTERMEDIARIES			

FORM SSA-1522 (7-68)

PAGE 1 OF 2

* Reduction of Original

APPENDIX 34: (Continued)

Monthly Intermediary Financial Report

SECTION D – Reconciliation and Analysis of Special Bank Account

FROM BANK STATEMENT		
15. Balance Beginning of Month per Bank		
16. Add: a. Payment Vouchers Drawn During Month		
b. Other Deposits		
17. Total to be Accounted for *(Line 15 plus Line 16)*		
18. Subtract: a. Checks Honored by Bank During Month		
b. Bank Charges		
19. Balance End of Month per Bank *(Line 17 minus Line 18)*		
FROM INTERMEDIARY'S BOOKS		
20. Add: Deposits in Transit		
21. Balance *(Line 19 plus Line 20)*		
22. Subtract: Outstanding Checks		
23. Balance End of Month per Books *(Line 21 minus Line 22)*		

	DATE	AMOUNT
24. Highest Balance During Month per Bank		
25. Highest Balance During Month per Books		
26. Lowest Balance During Month per Books		
27. Average Balance During Month per Books		

SECTION E – Remarks

A. Sum Total of all Dly. Clsg. Bank Bal. per Bank Statement _____

B. Average Dly. Clsg. Bank Balance per Bank Statement _____

C. Deposits in Transit EOM (Line 20)

1) Payment Vouchers

Number	Dated	Amount

2) Other Deposits

3) Total Line 20

D. Aging of Outstanding Checks at E.O.M. (Line 22)

Period Written	Age	# of Checks	Amount Outstanding
1) Dated current month	(0-30 days)		
2) Dated last month	(31-60 days)		
3) Dated 2 months ago	(61-90 days)		
4) Dated 3 to 5 months ago	(91-180 days)		
5) Dated 6 to 11 months ago	(181-365 days)		
6) Dated over 1 year ago	(over 365 days)		
7) Total E.O.M. (Line 22)			

E. The bank account ___ was ___ was not reconciled before this report was submitted.

(Attach additional sheets if necessary)

SECTION F – Certification

I certify to the best of my belief and knowledge that this data is accurate, complete and current as of the date of this certificate.

SIGNATURE OF CERTIFYING OFFICER	TITLE OF CERTIFYING OFFICER	DATE OF CERTIFICATION

FORM SSA-1522 17-001

PAGE 2 OF 2

* Reduction of Original

Monthly Intermediary Financial Report

Intermediary Name-Blue Cross & Blue Shield of Michigan — Page 3 of 1522
Location: 600 East Lafayette, Detroit, Michigan 48226 — Month Year
Letter of Credit Number : 75-08-1519

		Part A	Part B	Total	# of Bills Incl in Line 7 (c)
A)	Periodic Interim Pymts This Month:				
	1) Amt paid for Disabled				
	2) Amt paid for CRD				
	3) Amt paid for PPE				
	4) Amt paid for Aged				
	5) Total Amount Paid				
	No. of Bills Incl in Line 7 (c)				

		Part A	Part B	Total
B)	Reconciliation of O/S Accel Pymts:			
	1) Prior Mo. O/S (add)			
	2) Pymts Made to Prov during Mo. (add)			
	3) Repymts of Accel Pymts During Mo. (sub)			
	4) Balance-O/S-End of Month			

C)	Reduced or Suspended Pymts:	
	1) Prior Mo. Bal Withheld (add)	
	2) Pymts Suspended During Mo. (add)	
	3) Pymts Released During Mo. (sub)	
	4) Bal Withheld-End of Mo. (Tie to 2337)	

D)	Benefits Paid-Line 9F-Sec B:	
	1) Amt Paid for Disabled	$
	2) Amt Paid for CRD	$
	3) Amt Paid for PPE	$
	4) Amt Paid for Aged	$
	5) Total Pd (same as line 9(f)-(pg 1)	$

		Part A	Part B	Total
E)	Itemization of Retroactive Adj.-Sec C:			
	1) Lump Sum Interim Rate Pymts			
	2) Tentative Settlement			
	3) Post Audit Settlement			
	4) Net Total Columns (b) & (c)			
	5) Adj. Between Trust Funds (inc in Line 4 above)			

* Reduction of Original

APPENDIX 34: (Continued)

Monthly Intermediary Financial Report

Intermediary Name-Blue Cross & Blue Shield of Michigan
Location: 600 East Lafayette, Detroit, Michigan 48226
Letter of Credit Number: 75-05-4519

Page 4 of 1522
Month Year

		Amount	# of Providers
F)	O/S Current Financing Pymts:		
	1) O/S-Beg of Mo.		
	2) Amt Recovered during Mo (12(d))		
	3) O/S-End of Mo.		
	4) No of Prov with recoveries during mo.		

		# of Providers	Amount
Fa)	1) Accts turned over to GAO		
	2) Accts being turned over to BHI-RO/GAO		
	3) Extensions granted by BHI-RP		
	4) Other Delinquent Accts		
	5) Total O/S E.O.M.		

		# of Cases	Unrecovered Funds
G)	O/S Overpymts-End of Month:		
	1) O/S - End of Month		

		Part B
H)	End Stage Renal Disease Council Expenditures:	
	Month of _____	

I) Administrative Funds-1978 Current

J) Second opinion included in Section A Line #2 $500.00

* Reduction of Original

APPENDIX 35:

Payment Voucher on Letter of Credit Transmittal

☆ U.S. GOVERNMENT PRINTING OFFICE 1977—241—075/36

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
HEALTH CARE FINANCING ADMINISTRATION

PAYMENT VOUCHER ON LETTER OF CREDIT TRANSMITTAL

FROM: (Contractor)

TO: Health Care Financing Administration
Bureau of Health Insurance
Division of Contractor Operations
P.O. Box 1417
Baltimore, Maryland 21203

Letter of Credit
No. 75-05-

Payment Voucher
Nos. _____ thru _____

Date Drawn	Voucher Number	Serial Number	HI Benefits	SMI Benefits	Admin-Costs	Payment Voucher Total

TOTAL OF PAYMENT VOUCHERS

Hospital Insurance Benefits (20 x 8005)	$
Supplementary Medical Insurance Benefits (20 x 8004)	
Administrative Costs** (Breakout below for Fiscal Year Adjustments.)	
Total (Amount of Payment Vouchers)	$

ADMINISTRATIVE COSTS BREAKOUT

** Administrative Costs Applicable to Prior Fiscal Years:

FY

FY

FY

REMARKS:

FORM HCFA-1521 (1-77) (FORMERLY SSA-1521) PRIOR EDITIONS MAY BE USED UNTIL SUPPLY IS EXHAUSTED

Forward to Health Care Financing Administration

* Reduction of Original

*U.S. GOVERNMENT PRINTING OFFICE: 1978 620-010/4005 1-3

CMS LIBRARY
3 8095 00014154 5